Minnesota Medicine

Journal of the Minnesota State Medical Association, Southern Minnesota Medical Association, Northern Minnesota Medical Association, Minnesota Academy of Medicine and Minneapolis Surgical Society

Volume 34 **March, 1951** **No. 3**

HUMAN RELATIONS—INTERNATIONAL AND LOCAL

WARNER OGDEN, M.D.
Saint Paul, Minnesota

THE appalling succession of international catastrophes which have occurred during the past few months have caused all of us to look upon the future with serious apprehension. We have quite properly been inclined to blame the activities and policies of the postwar years for the mess in which we find ourselves, and certainly the present world crisis has followed hard upon inadequate, unintelligent, and dishonest efforts on the part of the heads of various nations, including our own, to solve international problems. In starting to prepare this address, I had at first a feeling of great futility, a feeling that a discussion of political medicine in the nation, or of medical difficulties in this state, or in this county society, would be totally superfluous.

And yet, as one tries to analyze the world dilemma, the confusion and bickering in Washington, or the minor difficulties in our local medical society, one fact stands out which is all important, one fact stands out which is common to any groups which are interdependent and compelled to work with one another. This fact is the difficult problem of human relations. And no large nations, or small groups, can get along together who do not recognize the vital necessity for the solution of this problem.

Du Nouy, in his book entitled "Human Destiny," presents man as a creature of evolution, slowly struggling up from the swamps of prehistoric time. To me he seems to prove rather effectively that this evolution has not been one of chance, of fortunate mutations, of survival of the fittest. Those species which showed the greatest adaptability, perfected themselves in their own form and eventually attained such a stability, such a suitability for their environment, that they reached a dead-end street in evolution. They finally perished when their environment was suddenly changed by world-wide climatic variations, such as the recurring glacial epochs, by variations in world bodies of land and water, or by inimical forces of other forms of life, varying in size from bacteria to saber-toothed tigers. Man, on the other hand, never became perfectly adapted. His evolution progressed intermittently but always consistently, not by chance but rather as though guided by the plan of some super-intelligence, some power greater than the simple laws of chance, mutation, and survival of the fittest. Man's physical development was achieved many thousand years ago, his intelligence developed rapidly, and was probably about as high among the ancient Egyptians, Chinese, and Greeks, as it is today. The present great scientific advances are chiefly the snowballing effect of utilizing rapidly accumulating stores of knowledge, rather than because we are now brighter than the Egyptians.

But the development of man's spiritual or moral nature has been slower, and is still racially in its early stages. It is true that through the centuries there has been a gradually increasing number who have thought primarily in spiritual or moral terms. It is true also that today there is more evidence of this spark of morality, but nevertheless many show a tendency to revert to the egocentric, amoral, physical creature of their prehistoric ancestry.

Now what has all this to do with human re-

Presidential address before the Ramsey County Medical Society, Saint Paul, Minnesota, January 29, 1951.

lations? Simply this—whether we be Russians or Americans, whether we be Republicans or Fair Dealers, whether we be patients or doctors, most of us have within us the ability to judge wisely, to make sacrifices, to understand and deal fairly with our fellows. And when nations—or politicians—or doctors violently disagree, it is probably due to one of three factors:

1. Lack of sufficient information and knowledge, and an intolerant refusal to learn more about the view of the opposition.

2. Egocentric or selfish reluctance to go part way to meet the other fellow.

3. The existence of relatively small, but vicious and amoral groups of individuals whose greed and ruthlessness stamps them as those whose evolution has not proceeded beyond the stage of the prehistoric man.

The solution of this situation, which is essentially a problem in human relations, is as simple and as frustrating at the international level as it is within our own nation, as it is between medical factions or between you and your patient.

At the county medical society level, we have tried, and I feel with considerable success, to improve human relations. We have done this in several ways:

1. By information and education—through a program of published advertising and radio talks; by making doctors available through our speaker's bureau for various public addresses on medical subjects; by improving relations with the press, the Saint Paul Association, the Community Chest, the Red Cross, and other civic organizations; and by trying to make every individual doctor a sort of ambassador of good will.

2. By trying to make good medical service readily available through the Emergency Medical Service organization.

3. By forming a Grievance Committee which has been able to adjust amicably many misunderstandings as to charges and services, as well as to crack down on a few cases of greed, selfishness, or intolerance on the part of physicians or patients.

Among our own membership we have a few problems. We have the case of the man who wishes full privileges in all the hospitals to do all types of work, even though he be inadequately trained and equipped to do so. A responsible medical society cannot permit such a man to place the health and lives of the public in jeopardy, in order to further his hunger for prestige or dollars. Then we have the super-trained specialist who may fail to appreciate the hard work, personality, and special abilities necessary for the man who is on the firing line in general practice. Many of us like to gripe about the hard work and poor pay from which we suffer in the particular field of medical practice we have chosen. But we forget that we were all reasonably free to choose whatever branch of medicine we wished, if we were willing to work for it, and that in complaining we are actually criticizing ourselves only, either for our lack of foresight in selecting our field, or for our indolence in training for it.

And this brings up another problem which is whispered in cloak rooms but never brought into public meetings—the age old matter of fee splitting. I do not propose to enter into this in detail at this time. I realize that special circumstances frequently affect various situations, and that it is impossible to cover all ramifications of so complex a subject with generalities. However, to use hypothetical illustrations, if I make a night call to catheterize a patient with acute prostatic obstruction and then refer him to a urologist for a transurethral resection, I do not expect to charge a fee in the operating room for turning on the hose to irrigate his bladder. I prefer to make a living in my own field, rather than as assistant water boy to a cystocope. And, if an obstetrician refers to me a case of cholelithiasis, he does not expect to charge a fee for standing at the operating table counting gallstones. He prefers to make a living as an obstetrician rather than as an assistant gallstone auditor. And certainly I think most of us will agree that when a specialist by any means, however devious, seeks to increase his referred work by purchasing it, or when any referring doctor, by any means, however devious, seeks to sell his patients to the highest bidder, these men are bartering in human suffering and have no place in an honorable medical society.

For all these various problems, it is the duty of the Ramsey County Medical Society to seek proper solutions. This is a democratic group where each man has an equal voice and equal opportunity for leadership. And we are fortunate here in having the excellent co-operation of the

Saint Paul Academy of General Practice, the Saint Paul Surgical Society, the Saint Paul Society of Internal Medicine, and other specialty groups, all seeking to improve ethical and scientific standards. And through these organizations, through our various committees, from the floor of these meetings, ample opportunity and channels are provided for discussing and correcting complaints, without resorting to ineffectual letters or cloak room oratory.

The Ramsey County Medical Society is your society. It is a good society because it recognizes its weaknesses and tries to correct them. It is my deep conviction that the physicians in this community as a whole, are outstanding in their professional relations, professional conscience, and professional ability. This is a recognized fact, not only locally, but by many individuals elsewhere in the nation, who are in a position to know. And, at this time, I wish to thank you men, and our various excellent committees, who by your co-operation and help have made this a year of progress. It has been a pleasure as well as an honor to work with you.

But, as stated in the beginning, in this period of world crisis, we cannot think of local matters only. We are more than Ramsey County physicians—we are American citizens. It is as American citizens that we have carried on the fight against socialized medicine. This has been a fight, not to preserve our incomes, but to preserve the personal health and economic integrity of the United States. It has been a fight against the same forces I have previously mentioned, against ignorance, selfishness, and ruthless greed. Senator McClellan of Arkansas has called those in Washington who sponsor state medicine, "Political racketeers in human misery." Dr. E. L. Henderson, President of the American Medical Association, has said, "The violent and vulgar attacks being made on the medical profession by those who would like to see it socialized, are direct evidence that the doctors of America have driven their message home." Those who cannot rally truth to their side usually resort to epithets. This is true in the case of certain labor agitators, of certain Congressional demagogues, and particularly of Oscar Ewing of the Federal Security Agency, even as it is true of Stalin, Mao Tse Tung, and their sycophants.

But, as American citizens, we must do far more than try to protect our own profession from socialization. Abraham Lincoln said, "If the United States is ever destroyed, it will be destroyed from within." That is the thing we must fear, that is the thing we do fear, whether we realize it or not. The inept fumblings with international diplomacy, the vacillating discordancies in formulating world-wide policies during the postwar years, and the present hysterical flutterings in Washington at our present dilemma, can be laid right on the doorstep of the American people, of you and me. The American voter has been influenced by greed, prejudice, intrenched privilege, laziness, rather than by national welfare —and 60 per cent of them have not bothered to vote at all.

Naturally, no one of us knows many of the answers but, certainly, this group of doctors knows the difference between right and wrong, between altruistic and egocentric objectives. It is possible, as Du Nouy suggests, that the human race is still at a primitive evolutionary stage in its development of spiritual and moral standards. It is even possible, as he suggests, that those elements representing the reversion to the ruthless viciousness of prehistoric man, may temporarily carry with them the great amorphous majority, and drive altruism and spiritual leadership into hiding. But, if we believe that the evolution of man is a progressive process, directed by a super-intelligence, we must believe in the ultimate resurgence of man's moral consciousness and spiritual strength.

Governor Langlie of the State of Washington, in a stirring appeal at the recent convention of the American College of Surgeons, called upon the doctors to step forward to their rightful place as leaders in the community. He said we fail to recognize our power and ability, individually and collectively, to influence a large number of people. The cheap politicians in our country and the dictators elsewhere, recognize it—that is why they try to destroy the medical profession by propaganda or concentration camps.

We physicians have a proud heritage. By education, by daily experience in human weakness and strength, by the necessity of dealing in human relations, by the fact that we studied medicine in the first place, we should be and we are singularly equipped to take a place of leadership,

(Continued on Page 217)

FERTILITY IN CRYPTORCHIDS

CHARLES E. REA, M.D.
Saint Paul, Minnesota

RECENTLY, a patient, twenty-five years old, upon whom I had performed orchiopexies fifteen years ago for bilateral abdominally retained testes, came to my office. Although he had been married four years, his wife had never become pregnant. The patient was concerned about his apparent sterility. Examination revealed the testes to be in the scrotum, but they were about one-third normal size. The secondary sexual characteristics were normal. A biopsy was taken of the right testicle; it showed no spermatozoa, an atrophic epithelium and a greatly increased interstitial stroma. The patient was told that it was unlikely that he would have children of his own and that he and his wife should plan to adopt children.

Because of this case, it was decided to check patients with bilateral undescended testes, who had had orchiopexies at least ten years before, and who were married, to determine their fertility.

Eight patients who had been operated upon at least ten years before for bilateral undescended testes, and who were married, were available for study. Their ages varied from twenty to twenty-five years. There were four patients with bilateral abdominally retained testes, two with bilateral inguinal testes and two in whom one testis was abdominally retained and the other inguinally retained. In six cases, it was mentioned that the scrotum was not developed at the time of operation. Wangensteen's modification of the Keetley-Torek operation was performed in all cases.

All these patients had been married for periods of from six months to five years. In no instance had the wife become pregnant. All these patients stated they were potent. The testes in each instance were in the scrotum, but none was normal in size. The testes were estimated to be one-third to one-half the normal size. Four of the patients submitted to testicular biopsy. The testes had atrophic germinal epithelium, and no spermatozoa were seen in any of the sections. It is interesting that three of the eight patients had consulted their home doctor about their sterility. Examination of the vaginal fluid after intercourse had failed to show spermatozoa in one case; and in another, the home physician reported that he could find no spermatozoa in the seminal fluid.

It is disturbing that all these treated cryptorchids are apparently sterile. On the contrary, Odionne and Simmons, McCollum, and others, have reported instances of fertility in cryptorchids treated by orchiopexy. However, these patients should be reviewed critically as to the time of examination after operation and also as to whether some of these cases may have been pseudocryptorchids.

According to the literature, spermatozoa have never been found in sections of the untreated cryptorchid testes. The sperm counts in treated or untreated cryptorchids never approach the normal, and if the undescended testes are operated upon after puberty and are small, they never attain normal size.

The experience of Sir Astley Cooper should be mentioned. A young medical student with bilateral undescended testes once consulted him about his condition. When Cooper told him he was like a castrate, the student committed suicide. At autopsy, it is stated that spermatozoa were present in both testes. If this is true, it would be a decidedly unusual finding; more likely, Sir Astley was dealing with a case of pseudocryptorchidism in which fertility was retained and not a case of true anatomically retained undescended testes.

There is no question but that placing the undescended testis in the scrotum allows the gonad to develop to varying degrees. The experimental evidence on this point has often been questioned because *normal* testes have been used experimentally: the gonads have been brought from the scrotum to the inguinal region or abdomen and then replaced in the scrotum after degeneration has occurred. The testes have had the normal potentialities all the time. However, Wangensteen has reported the case of a boy, twenty years old,

From the Department of Surgery, Medical School, University of Minnesota, Minneapolis, Minnesota.
Presented before the Minnesota Surgical Society, Saint Paul, Minnesota, November 17, 1950.

who had bilateral undescended testes upon whom an orchiopexy was done on both sides. Biopsies were taken at the stages of orchiopexy and at the autopsy twenty months after the final orchiopexy when the boy was accidentally killed. There was evidence of improvement in the germinal epithelium.

On reviewing the literature, one finds extreme differences of opinion: that the patient with undescended testes is always sterile, or that such patients may be fertile. One wonders whether the authors are stating opinions or impressions as facts. Many writers do not distinguish between pseudocryptorchidism and true undescended testes. Pseudocryptorchids commonly have spontaneous descent of the testes with or without hormone therapy. Also these patients are usually fertile. The testes of pseudocryptorchids develop into normal size. On the contrary, in my experience, a true anatomically retained testis never spontaneously descends, and hormone therapy is of little or no value in treating this condition. The farther the testis has descended, the easier it is to do an orchiopexy and the size of the testis determines what can be expected of it. In an older patient, with a small unilateral undescended testis, such testis is better removed as far as function or a cosmetic result is concerned. In bilateral undescended testes, the saving of the testes must be considered for the development of secondary sex characteristics. These characteristics seem to develop equally as well in either the treated or untreated cryptorchid, depending on the development of the testes.

Summary

Eight bilateral cryptorchids were studied as to their fertility. Orchiopexies had been performed at least ten years previously. It was discouraging that clinically at least all these patients were sterile and four of the patients who submitted to testicular biopsy had an atrophic germinal epithelium.

There is confusion in the literature as to fertility of cryptorchids because most authors do not differentiate between pseudocryptorchids and true undescended testes.

In our experience it would seem that the fertility of patients with true undescended testes is more potential than real.

Bibliography

1. Cooper, A.: Observations on the Structure and Diseases of the Testes. Edition 2. Edited by B. B. Cooper. Philadelphia: Leo & Blanchard, 1845. Pp. 47-52.
2. McCollum, D. W.: Clinical study of the spermatogenesis of undescended testicles. Arch. Surg., 31:290, 1935.
3. Odionne, W. B., and Simmons, C. C.: Undescended testicle. Ann. Surg., 40:962, 1904.
4. Rea, C. E.: Functional capacity of the undescended testes. Arch. Surg., 38:1054, 1939.
5. Wangensteen, O. H.: The undescended testis, its fate after satisfactory scrotal anchorage. Ann. Surg., 102:875, 1935.

HUMAN RELATIONS — INTERNATIONAL AND LOCAL

(Continued from Page 215)

not merely as doctors, but as American citizens. We must not waste our efforts in petty bickerings or destroy our influence in self-centered practices. We have, perhaps, been a bit too apologetic at times in discussing our profession with opposing groups. In the first part of this century, the doctor was a respected leader in his community. Let us live up to this heritage—let us be proud of our profession, and let us rededicate ourselves in these critical times to our duties as Americans. For only through proper leadership can the United States be strong militarily, intellectually, and spiritually, and, perhaps, in the strength and spirit of America lies the hope of the future. And for our personal consideration as doctors and as Americans, let me close with a familiar quotation from Abraham Lincoln, "I am not bound to win but I am bound to be true, I am not bound to succeed but I am bound to live up to what light I have."

MINNESOTA REPORTS HEART DISEASE

D. S. FLEMING, M.D., M.P.H.
Minneapolis, Minnesota
and
BERNARD WOLCYN, PH.D.
Saint Paul, Minnesota

IT is well known that heart disease in all its various forms has long been the leading cause of death in Minnesota. During 1949, deaths attributed to heart disease alone totaled 9,379—approximately one-third of all deaths in the state. Deaths from heart disease are greatly in excess of deaths from the next highest cause—cancer—which numbered 4,407 in Minnesota in 1949.

Ever since 1914, heart disease has kept its place as the leading cause of death in Minnesota. Through the intervening years, the number of deaths attributed to various forms of heart disease has shown a precipitous rise, increasing 480 per cent during the past forty years. Figure 1 shows the year-by-year increase in deaths from heart disease occurring in Minnesota as well as those registered by residence within the state. As in the case of cancer and other chronic diseases, the rise in number of deaths attributed to heart disease in recent years is due in part to two main causes—the aging of our population and the improvement in medical diagnosis.

Comparing the death rate from heart disease in Minnesota (as shown by figures from the State Department of Health) with that for the nation as a whole, we find that the Minnesota rate has remained consistently lower than the rate for the nation. In 1910, Minnesota's death rate per 100,000 population was 93.2. By 1948 the rate was 315.0 per 100,000, the peak having been reached with a rate of 323.5 in 1945. This in comparison to the 480 per cent increase in numbers of deaths is a 340 per cent increase in death rate. The national figure climbed from 158.9 in 1910 to 322.7 in 1948. The wide gap between the two sets of statistics that was evident during the early years of reporting is now being slowly closed to a point at which the death rate from heart disease in Minnesota at present almost coincides with that of the whole nation. Figure 2 shows this gradual narrowing. In Figure 3 the

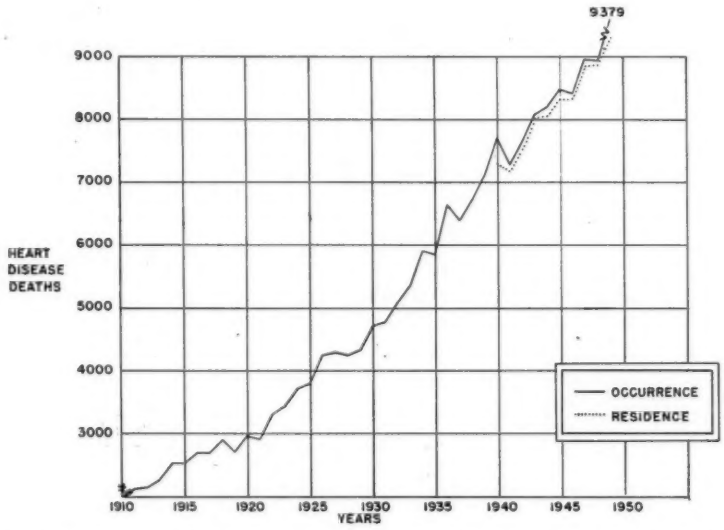


Fig. 1. Deaths from heart disease for Minnesota by occurrence and residence.

Dr. Fleming is Chief of the Section of Preventable Diseases, Minnesota Department of Health, and Dr. Wolcyn is Public Health Consultant, Division of Cancer Control and Heart Disease, Minnesota Department of Health.

death rate from heart disease is shown in relation to the total death rate in Minnesota.

The latter during the period between 1910 and 1950 fluctuated yearly within narrow limits, revealing a slow but gradual trend downward.

groups that make up the general classification of heart disease. These groupings, along with the percentage of all deaths reported for each group in Minnesota from 1943 to 1947, inclusive, are shown in Table I.

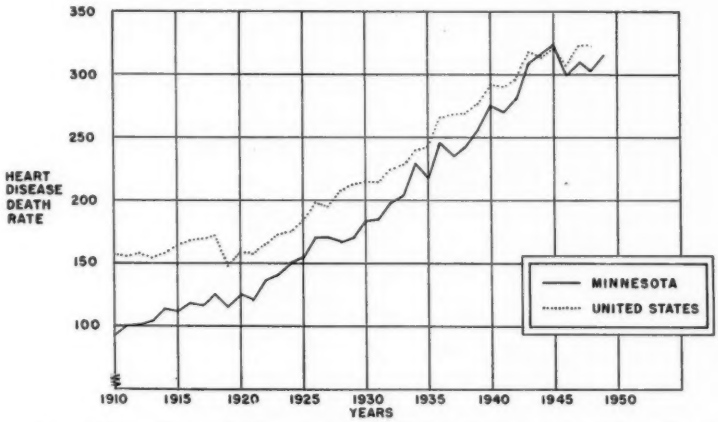


Fig. 2. Heart disease death rate per 100,000 for Minnesota and United States.

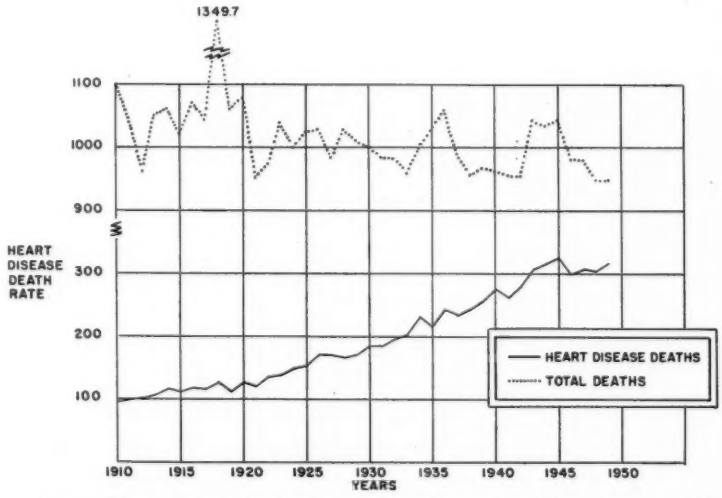


Fig. 3. Heart disease death rate in comparison to total death rate per 100,000 for Minnesota.

Heart disease death rate figures, on the other hand, show a distinct rise over the same number of years. While total death rates are dropping, heart disease death rates are on the increase. Heart disease as a cause of death in Minnesota is now taking about 225 more lives per 100,000 population than in 1910.

Figure 4 depicts the changes apparent during the 1941 to 1949 years, inclusive, in the six

TABLE I. PERCENTAGE OF DEATHS FROM VARIOUS HEART CONDITIONS OCCURRING IN MINNESOTA DURING THE YEARS 1943 TO 1947 INCLUSIVE

Disease	Percentage of Deaths by Classification of Total Heart Disease Deaths
Pericarditis	0.1
Acute endocarditis (except rheumatic)	0.4
Chronic affections of the valves and endocardium	10.0
Diseases of the myocardium	38.1
Diseases of the coronary arteries and angina pectoris	43.2
Other diseases of the heart	8.2

Table I and Figure 3 show that coronary disease and angina pectoris take more lives than any other condition in the general classification of heart disease, with myocardial disease ranking second. Both of these groupings show a steady uphill climb, with coronary disease and angina pectoris making the greatest rise. The other four groupings maintained an even pace over the period considered in Table I, with endocarditis and pericarditis occupying minor roles in the total heart disease picture.

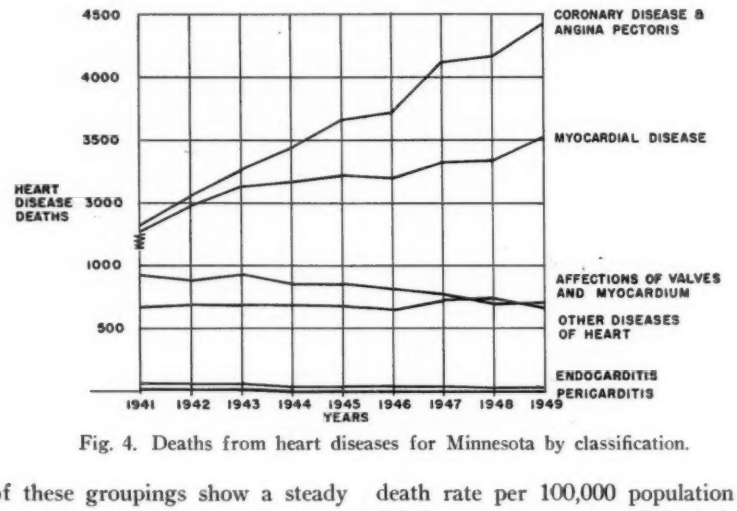


Fig. 4. Deaths from heart diseases for Minnesota by classification.

Summary

The number of deaths from heart disease, the leading cause of deaths in Minnesota, has increased 4.8 times since 1910. The heart disease death rate per 100,000 population has increased 3.4 times in the same period of time.

Heart disease now causes one-third of all deaths occurring in Minnesota.

Diseases of the coronary arteries, angina pectoris, and diseases of the myocardium lead as causes of death in the general category of heart disease.

THE FUTURE OF THE VETERANS ADMINISTRATION MEDICAL PROGRAM

The precipitate resignation of Dr. Paul B. Magnuson as chief medical director of the Department of Medicine and Surgery in the Veterans Administration has occasioned grave concern among all who are interested in the medical care of the veteran, particularly as he has stated in a letter to all doctors in the Department of Medicine and Surgery, that "there was too much interference in the running of hospitals and the authority for running hospitals."

This is a serious indictment. The issues involved can be appreciated only against the background of progress that has characterized the medical program of the Veterans Administration in recent years.

In the Spring of 1945 in Frankfort, Germany, the commanding general of the United States Ground Forces convened with the chief surgeon of the European Theater of Operations and his chief consultant to discuss the future medical care of veterans of the United States Army. It was May, the war in Europe was over and although Japan was still to be conquered, the future seemed full of hope and idealism. Under these propitious circumstances a complete reorganization of the Veterans Administration medical program was envisioned. To replace the archaic and bureaucratic system that had made veterans' hospitals places to be shunned, they planned a decentralized organization not unlike the Army's medical services in the European Theater where the care of the patient took precedence over all other considerations and where hospitals vied with each other for excellence. To make such a program an enduring one, they conceived the idea of linking it to those most stable of human institutions, the universities.

The ensuing years saw much of this concept come to fruition. Congress passed Public Law 293, which freed professional personnel from the restrictions of Civil Service Regulations. The universities supported the plan and took under their guidance the "affiliated hospitals." The names of Omar Bradley, Paul R. Hawley, Paul B. Magnuson, Elliott C. Cutler and Edward Cushing were identified with what Dr. Carroll, elsewhere in this issue of the *Journal*, has called "a transformation without parallel in the medical history of this country." Distinguished men in all branches of medicine were

(Continued on Page 235)

THE CHRONIC ALCOHOLIC AND ANTABUSE THERAPY

JACK V. WALLINGA, M.D.
Saint Paul, Minnesota

FROM an historical standpoint, it is only recently that alcoholism has come to be considered as a medical problem. For the past twenty centuries drunkenness has usually been thought of as a moral issue and punishable by the same legal action as other crimes against society. That such a punitive attitude has resulted in no improvement in the problem of alcoholism is only too apparent. In passing, it is interesting to recall that as recently as 1918 the Congress of the United States attempted to legislate the problem of alcohol out of existence. In reality the past twenty-five years have, for the first time, seen beginning attempts to attack the problem of alcoholism in the same scientific spirit that has obtained in the conquest of other diseases. From the medical standpoint it follows that the abnormal use of alcohol must be considered as a disease process if progress is to be made in its solution. One of the most recent attempts to treat alcoholism by means of a chemical agent is presented here.

The problem that is created by alcoholism, both socially and economically, is large. It is estimated that there are 750,000 people in this country who are confirmed, chronic alcoholics. There are almost 3,000,000 other excessive drinkers who border on chronic alcoholism.[11] The economic problem attributable to alcoholism in a single year is estimated at $432 million in potential wage losses; crime $188 million; accidents $89 million; hospital and medical care $31 million; and $25 million for the maintenance of drunken persons in local jails—a total of $765 million—and this still does not take into account the costs that cannot be figured in dollars: broken homes, deteriorated personalities, the damage done to good minds which otherwise would be capable of contributing positively to society.[6]

What is this disease for which the cost is so high? While the state of present knowledge permits no dogmatic statements with regard to etiology, it is felt that one of the major contributing factors is in the emotional area. Alcohol seems to serve a need similar to that of many neurotic symptoms in that it is effective in shielding from painful realities and unpleasant internal tensions. Menninger speaks of the phenomenon of self-destruction which occurs by irresistible addiction to repeated, excessive drinking of alcohol. We know of persons who, on their way to attempt suicide, have stopped for a drink and after a while, and several drinks, have forgotten for the time their original goal. Psychologically, alcohol addiction may be considered a form of self-destruction used to avert a greater self-destruction stemming from inner conflicts of which the person is only vaguely aware if at all. Such conflicts may take many forms, such as deep feelings of guilt, need for punishment, uncontrollable feelings of hostility, et cetera. Its further quality is that in a practical sense the self-destruction is accomplished in spite of and at the same time by means of the very device used by the sufferer to relieve his pain and avert this feared destruction.[15]

Alcoholics present a paradox in dynamics—the strong and largely unconscious wish to fail or relapse on the one hand, and the often desperate conscious desire to overcome the illness on the other. Freud has proposed the theory of the "death instinct," which may be one approach; Bergler emphasizes the role of super-ego tension and the driving compulsion for self-punishment. From studies concerned with the personality make-up of the alcoholic, a fairly characteristic pattern has evolved in which we see the alcoholic as a maladjusted and emotional immature individual. He frequently gives a history of an excessive dependence on his mother and strong mixed feelings in that relationship. He craves independence and earnestly desires to be free from that maternal bondage which so frustrates him, but he is utterly unable to break away from the pattern of the mother's domineering influence. This set of mixed feelings, the alternating love and hate for the mother, accounts for much of

This work was done in the Department of Psychiatry, University of Minnesota Hospitals, with the cooperation of the Department of Internal Medicine.

A part of this material appeared in the *Bulletin of the University of Minnesota Hospitals and Minnesota Medical Foundation* for Nov. 24, 1950.

the hidden frustration and the otherwise unrecognized mental and emotional conflict which characterizes these individuals.[18]

The alcoholic personality demands quick relief from his troubles. He is generally nervous, restless, and always craving something. He dislikes following a routine and does not want to be tied down to a day-by-day job. He longs to be a "big shot" but dislikes competition and is greatly influenced by his associates. He is markedly passive in nature—dictators are never alcoholics. Usually the alcoholic has a kind disposition and is cruel or sadistic only when extremely frustrated, but he does like to be humored and coddled. He often shows a serious lack of adequate goals in the reality of living. The alcoholic is not a good marital risk. He seems selfish in his love life, he is frequently sexually maladjusted, and because of his strong dependent personality trends it is difficult for him to assume responsibility and meet the obligations of adult behavior. The problem drinker is notorious for the intensity of his infantile needs and the demands he makes on those around him. The flight into alcoholic narcosis may represent an attempt to recapture the infantile feeling of omnipotence.[16]

Investigations of the early life histories of chronic alcoholics have suggested that many were more or less serious problems at "weaning time." The majority were not weaned until the second year, sometimes well into the second year. In babies we see that milk is in a way the baby's nervous or emotional anesthetic. That is, it does for the perturbed or nervously tense infant exactly what alcohol does for the frustrated and nervously tense adult.

In the individual history of an alcoholic it is difficult to say when socially and relatively harmless drinking was superseded by a more malignant and compulsive type of drinking. This is one of the insidious dangers of alcohol for unstable individuals.

Another aspect of this problem which must be kept in mind is the pharmacological factor. Nutritional deficiencies may be a cause as well as a result of chronic alcoholism. Neuro-endocrine disturbances are probably especially significant, and recent work suggests that many alcoholics are of generally asthenic habitus and deficient in gonadal and adrenocortical hormones.[19]

Of the numerous varieties of medical treatment offered to the chronic alcoholic in the past, none has given satisfactory results. Institutionalization has been tried frequently, sometimes for periods as long as a year, but this has not produced, with any frequency, the desired abstinence. Psychotherapy has not been too successful except in highly selected cases. From the point of view of treating large numbers of alcoholics, Alcoholics Anonymous has been the most effective tool yet devised. Here again there exists an absolute criterion for such therapy in that the Alcoholics Anonymous program means that the alcoholic has insight, that is, comes to Alcoholics Anonymous voluntarily with the admission that he is a drunkard. The aversion, or conditioned reflex, treatment based on Pavlov's work has had some success. First apomorphine, and recently emetine, has been the basic drug in this treatment, which consists of the patient being hospitalized and conditioned against alcohol by the simultaneous administration of one of these vomit-producing drugs and liquor. Using this treatment in carefully selected cases, Lemere[14] and others report 66 per cent successful abstinence for six months to two years after treatment and 46 per cent abstinence in cases followed four years or more.

In 1914, Koelsch reported that workers who handled cyanamide experienced flushing of the face, headache, accelerated and deepened respiration and pulse rate, and a feeling of giddiness on taking even a small amount of alcohol.[13] It has also been known for several years that the fungus *coprinus atramentarius*, though innocuous to man when taken alone, gives rise to similar unpleasant symptoms when alcohol is consumed.[3] In rare cases of idiosyncrasy to alcohol similar symptoms appear without any other drug being taken.

Antabuse (tetraethylthiurium disulfide) was discovered by Doctors Hald and Jacobsen in Denmark while they were working to develop a drug effective against certain intestinal worms.[7] As an incidental observation they noticed that a person taking this drug, upon ingesting alcohol in any form, always developed a group of symptoms which made drinking difficult. The drug by itself is nontoxic. The lethal dose in animals is reported to be 3 grams per kilo of body weight.[9] In clinical trials single doses of up to 6 grams and daily doses of 0.25 to 0.60 grams for several months were given without producing any subjective or

objective symptoms apart from those following the ingestion of alcohol.

The clinical application of Antabuse in the treatment of alcohol addiction was first made by Jacobsen and Martensen-Larsen in Denmark. They found that when a person has taken Antabuse previously, the intake of alcohol results in the following chain of symptoms. After five to fifteen minutes the person has a feeling of heat in the face. A few minutes later an intense vasodilitation is observed in the face and neck, sometimes extending over the upper part of the chest and arms, making the whole area purple-red. Vasodilitation of the sclerae is also characteristic. The pulse rate is increased to 120 to 140. The blood pressure is unaltered or slightly depressed, and respiration is increased. Sometimes nausea begins thirty to sixty minutes after the ingestion of the alcohol. In such cases the intense flushing disappears and is replaced by facial pallor, and there is a considerable fall in systolic and diastolic blood pressure. Copious vomiting may occur. Large doses of alcohol may result in dizziness, occasionally unconsciousness and convulsions, and deaths have been reported. These symptoms are usually accompanied by an intense feeling of discomfort to the patient, who has a pulsating headache, palpitation, dyspnea, and extreme restlessness. Frequently the patient complains of a constricted feeling in the neck, "as though the collar were too tight," also a feeling of "premature hangover" which they find most disagreeable. Altogether, the discomfort is so intense that, once experienced, it discourages the large majority of patients from further attempts to use alcohol as long as they are taking the drug. These unpleasant effects usually last an hour or two, occasionally up to five hours, following which the person is quite fatigued and likely to sleep for a few hours. Then he awakens feeling fairly well.

Hypersensitivity to alcohol generally begins three to four hours after the ingestion of a single dose of Antabuse and is fully developed during the next twenty-four hours; on some clinical trials, however, this latent period was as long as forty-eight hours.

Antabuse is eliminated slowly in man, largely in the feces in unaltered form. Because of this slow elimination the effect of a single dose lasts up to eight days.

In prescribing Antabuse it is important to remember that alcohol in any form will start the usual chain of symptoms. Alcohol in such disguised forms as cough syrups and brandy sauces on puddings has produced symptoms; and even the liberal use of vinegar which had begun to ferment on a boiled cabbage, ham, and cole slaw dinner has, in at least one instance, made a person receiving Antabuse ill. Two cases have been reported where Antabuse patients have been noticeably uncomfortable after alcohol backrubs.[4]

Occasional mild effects are observed in patients receiving Antabuse. Most commonly complained of is lassitude and tiredness for the first few months. This may be handled adequately by giving the Antabuse in the evening when the sedative action is desirable. Mild allergic cutaneous reactions have been reported, as have dizziness, interference with taste, impotence, and mild gastrointestinal disturbances.[1] All of these symptoms respond to reduction in dosage. A possible explanation of these side effects is offered in a report by Edwards[2] that Antabuse alone partially inhibits cellular respiration.

The actual mechanism of the alcohol-Antabuse reaction is not yet known, but it is believed to be due to an increase in the acetaldehyde in the blood. This may be formed by some unknown reaction of the drug on the enzymes oxidizing alcohol in the organism.[8] Perhaps after treatment with Antabuse the normal elimination of alcohol is partly or completely blocked, and under the influence of the alcohol dehydrogenase a higher proportion of alcohol than normal is oxidized to acetaldehyde. Another possibility is that alcohol hydrogenase is highly activated by Antabuse. A significantly increased acetaldehyde concentration in the blood has repeatedly been demonstrated in persons treated with Antabuse who ingest alcohol.[7] Also the sequence of symptoms characteristic of the Antabuse-alcohol reaction can be duplicated by intravenous injection of acetaldehyde.

The contraindications to Antabuse therapy appear to be relative, and are usually psychiatric rather than organic. The original investigators treated all persons with alcoholism who consulted them, and they found no absolute contraindications.[10] However, the treatment is not without danger, and deaths have been reported.[5,12] Two deaths have been reported in Europe in

patients treated with Antabuse who were suffering from diabetes mellitus, but other diabetics have been treated without complications.[17] Patients with cardiac damage present a greater risk, and extreme caution must be used in such cases. Bennett reports a case of mild heart disease with minimal electrocardiogram damage who had an electrocardiogram during an Antabuse test reaction which showed an alarming increase in coronary insufficiency.[1]

Asthma, nephritis, goiter, and epilepsy also indicate a cautious approach to Antabuse therapy. Moriarty[17] believes that the important psychiatric contraindications are drug addiction in the patient, as he would be likely to resort to more of the habituating drug when alcohol is removed as an escape; and the presence of psychosis, in which the patient might use Antabuse as a means of suicide or otherwise misuse the drug. A patient lacking insight, thus unable to accept the need of the treatment, would also be a poor candidate for Antabuse therapy.

Ten persons who have received treatment for alcoholism with Antabuse at University of Minnesota Hospitals in the past fourteen months are reported here. These patients volunteered for the treatment with the knowledge that this was its first use here and that it was still an experimental drug. Alcohol had constituted a problem for each of them for periods of from seven to thirty years. The criteria for selection were that the person be sincerely interested in receiving help, to the extent of agreeing to stay in the hospital for three weeks while treatment was begun; that they were of average intelligence, and that there were some positive factors in their previous personalities and work adjustments.

On admission to the hospital the procedure which was to be followed and the degree to which their co-operation was necessary was explained to them. Complete history and physical examination were done, as well as laboratory studies including electrocardiogram, urinalysis, complete blood count, serum bilirubin, thymol turbidity, cephalin cholesterol flocculation, and bromsulfalien retention at forty-five minutes after injecton of 5 mg. per kilogram of body weight. Continuous daily twenty-four-hour urine specimens for coproporphyrin determinations were collected throughout each patient's hospital stay; however, the porphrin results were inconclusive concerning the effect of the Antabuse-alcohol reaction on the urinary coproporphyrins. After a drying-out period of four or five days the patient was given an initial test of alcohol, usually 200 c.c. of 95 per cent ethyl alcohol in grape juice over a three-hour period, to obtain an idea of the individual's tolerance. Then approximately five days later, Antabuse was started, 1 gram the first day, and 0.5 grams daily thereafter as the maintenance dose. On the sixth day of Antabuse therapy the patient was given alcohol in order that he might have first-hand experience with the symptoms of the alcohol-Antabuse combination. An initial amount of 10 c.c. of 95 per cent ethyl alcohol was given orally. Pulse and blood pressure were checked at five minute intervals during the reaction. A second 10 c.c. quantity of alcohol was given approximately fifteen minutes later; and if the reaction was not then marked, a third 10 c.c. drink was offered to the patient, this about thirty minutes after the initial drink. This quantity was usually sufficient to demonstrate convincingly to the patient the severe symptoms which follow the ingestion of alcohol while taking Antabuse. The reaction which followed was the characteristic series of symptoms which was described earlier. In one of our female patients, 8 c.c. of 95 per cent alcohol was sufficient; in another case it was necessary to give 45 c.c. in order that the patient experience a reaction of the desired intensity. At the time of the test reaction it was impressed on the patient that such symptoms would follow the intake of alcohol as long as the patient continued taking Antabuse. He was also told that his sensitivity to alcohol would increase as he continued to take the drug and that any drinking would result in these symptoms and that heavy drinking might well endanger life. It was felt that some of the patients, most often those who had received the aversion treatment in the past, had some suspicion that the alcohol might have been tampered with, so they were encouraged to try a drink if they so desired, after leaving the hospital, but they were warned that if they did so, they should drink slowly and with extreme caution. At least two of our group did test themselves in this manner after leaving the hospital.

In two instances the initial Antabuse-alcohol test reaction was not severe enough so that the patients thought it would deter them from

further drinking. The test was repeated in two or three days with 40 c.c. of 95 per cent alcohol given more rapidly, and both patients were then sufficiently impressed. It was interesting to observe in the two unsuccessful first trials here, and with a majority of the other patients in the group, that they expressed marked disappointment that they were not made even more ill when they took alcohol, almost as if they desired the drug to have a punishing quality.

Two of the patients in this group complained of mild gastrointestinal discomfort during the first week on Antabuse. In three other cases marked weakness, dizziness, tremor, incoordination, and restlessness were complained of during the first two or three weeks after leaving the hospital. There were no objective findings, however, and it was felt that these complaints most probably reflected the individuals' anxiety and apprehension about the loss of support that alcohol had previously offered them.

The Antabuse-alcohol reaction took place in all but one case without disturbing or unforeseen effects. In that case, a hypentensive patient complained of moderately severe anginal pain coincident with a blood pressure drop from 220/140 to 120/60 when alcohol was administered. No after-effects were observed, however.

After a satisfactory Antabuse reaction in the hospital, the patient was discharged and thereafter followed and supplied with more Antabuse in the Psychiatric Outpatient Clinic of University Hospitals. It was found desirable to reduce the daily dose of Antabuse to 0.125 grams in two cases and to 0.25 grams in another instance because of persisting uncomfortable side effects of dizziness and sleepiness.

Two of the subjects have been re-evaluated concerning liver function status three months after starting Antabuse and two others after six months on the drug. This data has been compared with the initial liver function tests, and no evidence of liver damage has been found.

All of these patients volunteered for Antabuse treatment, although in several of the cases pressure was brought to bear by the family or employer, and in each case the person had recognized before he or she came for treatment that alcohol constituted a severe problem for him and one in which he needed assistance. Individual psychotherapy was offered but not encouraged in order that the effectiveness of Antabuse alone might be better evaluated. The status and mechanism of Antabuse was discussed frankly with each patient during his hospitalization, and the theme was stressed that the effectiveness of the treatment depended on his continuing to take the drug regularly after leaving the hospital.

At this time two of the group are known to have discontinued the use of Antabuse. Significantly, perhaps, these two were receiving the most pressure from family or employers to undergo treatment. One was in the process of commitment to a state hospital for alcoholics. This was postponed when arrangements were made by his family for him to receive Antabuse, but commitment was subsequently carried through by his family when he was returned from another state in a chronic alcoholic condition five weeks after discharge from the hospital. The other failure was a nurse who was threatened with the loss of her job if she did not receive treatment, and she discontinued Antabuse a month after discharge from the hospital. Another patient stopped taking Antabuse and entered an alcoholic episode of a month's duration four months after leaving the hospital, but he subsequently returned voluntarily and has continued to do well on Antabuse since then. Still another of the group has discontinued the drug, but has not returned to drinking. The others have been getting along well and successfully staying away from alcohol for periods ranging from six to fourteen months.

It is apparent that the taking of the daily Antabuse dosage is voluntary and that, conversely, the patient can discontinue it at will. For this reason Antabuse therapy has no value in the patient who does not have insight into his alcoholic problem, thus who does not regard it as a real problem in his life, but who may be motivated to give lip-service to the treatment because of impending legal trouble, threat of divorce, et cetera. As an adjunct to therapy, however, it is our impression that Antabuse treatment has real value in the type of patient who recognizes that he is drinking abnormally but who does not seem able to stop drinking on a voluntary basis without outside help. In this patient, often the successful professional or business man or woman, Antabuse serves as a useful method of extending out into a three or four day future the earnest and sincere wish to stop drinking, coupled with the adequate

recognition that if the drinking pattern is not interrupted, disaster or destruction of some type will follow. Several of the patients in this series have made the obvious remark that it is relatively easy to make the decision to take a pill on getting up in the morning when resolutions are high and then to relax in the knowledge that they cannot drink for at least three or four days. These patients tended to adopt the philosophy of thus keeping three or four days "ahead of the game."

Most patients made no attempt to avoid contact with liquor and attended social functions where cocktails and other drinks were served. One patient consistently maintained his usual late afternoon contacts with a hard-drinking group of friends of long standing who were accustomed to meet in a local bar. He felt that his friends were privately envious of his success at abstinence as judged by their frequent attempts at humor about his being "on the wagon."

It is recognized that one cannot draw valid conclusions after one year of follow-up in a series this small. However, it appears clear that as long as a person maintains his Antabuse dosage, it is a physiological impossibility for him to drink. In this regard it was our definite impression that the Antabuse-alcohol combination, as seen in the therapeutic trials in the hospital with small amounts of alcohol, contains a possible threat to life itself. If, for example, an Antabuse patient were to take rapidly a relatively large amount of alcohol (4 to 6 ounces of 100-proof whiskey), it seems likely that death might result from circulatory collapse unless the patient were immediately taken to a hospital and given active supportive therapy by a physician who was aware of the cause of the prostration. No patient should be given Antabuse without permitting him to experience a therapeutic trial with alcohol under hospital conditions. Only in this way can he adequately realize, intellectually and emotionally, how profound the reaction is. Toward the same end, each patient taking Antabuse should carry with him an identification card which states he is taking Antabuse, together with the name of the physician who is treating him. Antabuse patients should also be instructed about ingesting materials which they might not know contained alcohol, such as cough medicines, elixirs, et cetera.

Finally, it is important to keep in mind that a psychotherapeutic program which aims at permitting the patient to deal with underlying conflictual material should be an integral part of the total therapy of which Antabuse may be a valuable adjunct.

References

1. Bennett, A. E.; McKeever, L. G., and Turk, R. E.: Antabuse in the treatment of alcoholism. California Med., 73:141, (Aug.) 1950.
2. Edwards, T. P.: The effect of tetraethylthiurium disulfide (Antabuse) on cellular respiration. Texas Rep. Biol. & Med., 7:684, 1949.
3. Fischer, J.: Svenska Lakartidn, 42:2485, 1945.
4. Garber, R. S., and Bennett, R. E.: Unusual reactions with Antabuse. J. M. Soc. New Jersey, 47: 168, (April) 1950.
5. Gelbman, F., and Epstein, N. D.: Initial clinical experience with Antabuse. Canad. M. A. J., 60:549, (June) 1949.
6. Haggard, H. W., and Jellinek, E. M.: Alcohol Explored. New York: Doubleday, Doran and Company, 1942.
7. Hald, J., and Jacobsen, E.: The formation of acetaldehyde in the organism after ingestion of Antabuse (tetraethylthiurium disulfide) and alcohol. Acta Pharmacol. et Toxicol., 4:305, 1948.
8. Hald, J., and Jacobsen, E.: A drug sensitising the organism to ethyl alcohol. Lancet, 2:1001, 1948.
9. Hanzlik, P. J., and Irvine, A.: The toxicity of some thioureas and thiuramdisulphides. J. Pharmacol., 17:349, 1921.
10. Jacobsen, E., and Martensen-Larsen, O.: Treatment of alcoholism with tetraethylthiurium disulfide (Antabuse). J.A.M.A., 139:918-922, (April 2) 1949.
11. Jellinek, E. M.: Recent trends in alcoholism and in alcohol consumption. Quart. J. Studies on Alcohol, 8:1-42, (June) 1947.
12. Jones, R. O.: Death following the ingestion of alcohol in an Antabuse-treated patient. Canad. M. A. J., 60:609, (June) 1949.
13. Koelsch, F.: Ueber neuartige Gewerbliche Erkrangungen in Kalkstickstoffbetrieben. Munchen med. Wchnschr., 61:1869, 1914.
14. Lemere, M. A., et al: Conditioned reflex treatment of chronic alcoholism. Am. J. Dis. Child., 3:243, (Aug.) 1942.
15. Menninger, Karl A.: Man Against Himself. New York: Doubleday, Doran and Company, 1942.
16. Moriarty, J. D., and Pearson, A. W.: Principles of therapy of the alcoholic patient. Ann. West. Med. & Surg., 4:127-130, (March) 1950.
17. Moriarty, J. D.: Antabuse in treatment of alcoholic patients. California Med., 73:144, (Aug.) 1950.
18. Sadler, W. S.: Modern Psychiatry. St. Louis: C. V. Mosby Company, 1945.
19. Tintera, J. W., and Lovell, H. W.: Endocrine treatment of alcoholism. Geriatrics, 4:274, (Sept.) 1949.

THE ASSASSINATION AND GUNSHOT WOUND OF PRESIDENT JAMES A. GARFIELD

OWEN W. PARKER, M.D.
Duluth, Minnesota

ON July 2, 1881, at 9.30 a.m., James Abram Garfield, twentieth President of the United States, while walking arm in arm with his Secretary of State, James G. Blaine, in the depot of the Baltimore & Potomac Railroad at Washington, D. C., was shot by Charles Guiteau.

It was another great shock to the Nation comparable to the assassination of President Lincoln. I recall the news of the event as distinctly as though it were yesterday. It reached out to our farm home on the wide sweeping mystic prairies of Iowa where "the lark calls, the wind sweeps, the prairie grasses quiver and sing a wistful roving song of hoof and wheel and sail"—not by radio or telegraph or train, but by the slow turning of loaded wagon wheels along the winding deep-rutted prairie trail of the time. Our neighbor had gone to town and brought back the news that President Garfield was shot. Young as I was, I sensed a tragedy to our country. My vivid impression of the event gave me an interest in Garfield which has always remained. I read all the news I could get of his long illness, his death and last rites with burial at Lakeview Cemetery in Cleveland, Ohio.

I read biographies of him and in later years visited his tomb and the spot where he fell in the old Baltimore & Potomac Railroad Station marked by a star on the floor. It is a remarkable fact that when the Nation gave expression to its sorrow over the death of Lincoln, Garfield should have been so notably the voice which spoke that sorrow—it was an emergency oration before an excited, sorrowful, turbulent and angry audience in New York City. The oration ended with those memorable words, "God Reigns and the Government at Washington Still Lives." He quieted the wild passions of the crowd, and it became strangely silent. Fate is ever unknown. Garfield, himself, became President and fell as did Lincoln by the hand of an assassin. "God Reigns and the Government at Washington Still Lives" was still true.

My first remembrance of a Presidential campaign was that of Garfield and Hancock in 1880. Both were generals in the War Between the States. James Abram Garfield had risen from the ranks and was a hero at Chickamauga, and Winfield Scott Hancock, the Superb, was a West Point graduate and a hero at Gettysburg. Both were popular and gallant and able men. The election went to Garfield by a fairly close margin and he became the twentieth President.

His nomination at Chicago was spectacular and dramatic. General Ulysses S. Grant had returned from a trip around the world and had received greater honors by the countries of the world than any living person of the time. He returned home a triumphant hero of the world. He was supported for a third term as President by the so-called stalwarts of the Republican Party, headed by that great orator, the imperious, powerful and indomitable Senator Roscoe Conkling of New York. Conkling was a handsome man of wonderful physique and courage—a massive, finely shaped head with hyperion curls. Blaine and Conkling did not get along well, and Blaine in a speech of ridicule spoke of Conkling as "He of the Turkey Gobbler Strut," which Conkling, it is said, never forgave.

When Conkling made his great speech nominating General Grant, it is said someone cried, "Where does he hail from?" Conkling replied in the famous words, "You ask me where he hails from? This shall my answer be—he hails from Appomatox and its famous Apple Tree." At the opening of the convention General Grant had the largest number of delegates but not enough for nomination.

The great James G. Blaine of Maine and Senator John Sherman of Ohio, brother of General William Tecumseh Sherman, and former Governor William Windom of our own State of Minnesota were also candidates. Garfield attended the convention as a delegate, supporting Senator John Sherman of Ohio, and made a great nominating speech for Sherman, which was wildly acclaimed and struck a strong note in the convention.

After long balloting with the Grant men

standing firm, but not gaining, the convention suddenly turned to Garfield and rapidly nominated him. It was a great personal triumph for Garfield.

Garfield's ancestors on his father's side came to Massachusetts in the early Colonial days and were of Welsh descent. His mother's ancestors were French Hugenots and also came in Colonial days to American shores. His father and mother settled in the Western Reserve near Cleveland. There Garfield was born in 1831.

In fighting a forest fire his father, a strong, powerful man, became exhausted and probably developed pneumonia and died, when Garfield was just a young boy. Left with his mother and brother and sister, he had to make his own way in the world. His mother lived to see him enter the White House as President.

They were greatly devoted to each other. Garfield worked hard as a boy. At one time he was employed on the Canal. He graduated from Williams College, Williamstown, Massachusetts, taught school, at times preached sermons in the churches. He entered the war between the states, was rapidly promoted, becoming a general. He was elected to Congress during the war—an office he held for many years—and then was elected to the United States Senate from Ohio, just before his nomination for the President of the United States.

There was much bitterness, fighting and feuding in his party during his first few months of the Presidency, which had caused him much worry and difficulty, and to add to his troubles, Mrs. Garfield became sick with typhoid fever just after they entered the White House. She was recovering at Long Beach at the oceanside in New Jersey.

It was the purpose of the President, as soon as the pressing cares and anxieties of his great office could be put aside, to join his wife by the seaside and to enjoy with her a brief respite from the burdens and distractions which weighed him down, so with the coming of July first and the adjournment of Congress, he proposed to rest with his family for a brief season by the sea, after which he would visit Williams College to make arrangements for the admission of his two sons to his alma mater.

On the morning of July 2, 1881, he proceeded to carry out his plans. Several members of the Cabinet, headed by the Secretary of State, Mr. Blaine, were to accompany him to Long Beach. A few ladies, personal friends of the President's family, were in the company, and as the hour of departure drew near, they gathered at the depot of the Baltimore & Potomac Railroad to await the train. The President and Secretary Blaine were somewhat later than the rest. On the way to the depot the President, always buoyant and hopeful, was more than usually joyous and grateful that the relations between himself and the members of the Cabinet were so harmonious, and that the Administration was a unit. Amongst his Cabinet, besides Secretary Blaine, were Robert Todd Lincoln, son of President Abraham Lincoln, Samuel Kirkwood, war governor of Iowa, and our own former governor of Minnesota, William Windom.

When the carriage arrived at the station at 9:30 a.m., the President and Mr. Blaine entered the Ladies' Waiting Room, which they passed through arm in arm as mentioned above. A moment afterwards, as they were passing through the door into the main room, two pistol shots were heard. Mr. Blaine saw a man running and started toward him, but turned almost immediately and saw that the President had fallen. He had received a pistol shot wound from a British Bulldog revolver, which carried a 44/100 central fire cartridge, powder 20 grains, weight of bullet 200 grains. He was fired upon at a distance of eight feet from behind. Dr. Townsend, Health Officer of the District, who was the first doctor to come to the scene, is reported to have said, "I found the President, when I arrived at the Baltimore & Potomac depot, about five minutes after the shooting occurred, in a vomiting and fainting condition. From the pulse at the wrist I thought he was dying. I had the head lowered and administered aromatic spirits of ammonia and brandy to revive him. This had the desired effect and the President regained consciousness—was asked where he felt the most pain, to which he replied, 'In the right leg and foot.' I asked him the character of his pains and he said it was a prickling sensation. He rallied considerably and I proceeded to examine his wounds. I found that the bullet had entered his back two and one-half inches to the right of the vertebrae. I introduced my finger into the bullet wound. Some hemorrhage followed. After examination of the wound the President looked up and asked me what I thought of it. I answered I did not consider it serious.

He continued, 'I thank you, Doctor, but I'm a dead man.'"

Dr. W. W. Bliss, surgeon in charge of President Garfield throughout his illness, wrote a complete history of the President's case immediately following his death. Excerpts from this detailed history are here presented:

The great interest which has been manifested by the medical public in the surgical history of the case of President Garfield, and my close and direct connection with it as surgeon in charge, from the time I was summoned until his death, imposes upon me the obligation of giving, even at this early date, a general summary of the salient points connected with its diagnosis, treatment, and pathology.

Immediately after the shooting of President Garfield, on the morning of July 2, I was summoned by the Secretary of War to take charge of the case. I was conducted to an upper room in the building, where I found the President lying upon a mattress, in a semiprone position, on the left side. He presented the appearance of perfect collapse, the lines of expression were lost, there was extreme pallor, sighing respiration (about eight or ten per minute); pulse exceedingly small, feeble, and frequent, and ranging about 120. Large beads of perspiration stood upon his hands and forearms.

The President complained of a sense of weight and numbness, and subsequently of a tingling sensation and pain in the lower extremities. With a view of exploring the wound to ascertain the course of the ball and the organs involved in its passage, I introduced a Nelaton probe which took a direction downward and forward, on a line which would represent a point of exit four inches to the right, and nearly directly opposite to the umbilicus. The point of entrance of the ball, which was oval and sharply cut, was on the right side, four inches from the median line of the spine, and on a line with the eleventh rib. A slight discharge of blood was oozing from this orifice, and had soiled the clothing. I passed the probe in the direction previously indicated, through the tenth intercostal space, for a distance of three and one-half inches from the surface of the body, to what appeared to be a cavity, and I was unable to detect any foreign substance beyond the rib to indicate the presence of fragments of bone or the missile. In attempting to withdraw the probe it became engaged between the fractured fragments and the end of the rib, and could not be liberated until pressure was made upon the sternal end of the rib so as to slightly elevate its fractured extremity.

I then passed the little finger of my left hand to its full extent into the wound, which developed the character and extent of the fracture of the rib, and was only able to reach a point on a line with the inner surface of the rib, where it came in contact with what appeared to be lacerated tissue or comparatively firm coagula, probably the latter. After withdrawing my finger I made an exploration with a long, flexible silver probe, which I suitably curved before entering, and gently passed it downward and forward, and downward and backward in several directions, with a view of indicating the course of the ball, if it had been deflected by contact with the rib, and meeting with resistance from soft parts. I desisted and excluded the probability of deflection, being inclined to the opinion that the ball had entered the liver, which, if true, would not warrant further exploration in that direction.

The President repeatedly requested that he be taken to the White House, and after further consultation and a full understanding of the manner and detail of his transfer, his speedy removal was agreed upon.

On his arrival at the White House by ambulance, a careful examination was made of his condition. The pulse continued feeble, frequent, and extremely compressible; the respiration was slow and sighing; extremities and surface cold, with occasional vomiting and profuse perspiration over the entire body; voice husky, with constant complaint of severe pains in the inferior extremities. He was placed upon his right side, so as to make the wound dependent, to facilitate drainage, and keep the viscera in contact with the injured parietes, with a view of preventing further hemorrhage and looking to the possible adhesion of the injured parts to the peritoneum. Water was given in small quantities, often repeated. This was necessitated by the extreme thirst from which the patient suffered.

A hypodermic injection of one-eighth of a grain of morphine and one-eightieth grain of atropia was administered to control the pain in the extremities, and as a more permanent stimulant to assist reaction. This was about 10 a.m., July 2.

There was but little change in the condition of the patient, either in temperature, respiration, or pulse, until about eleven o'clock, when it was determined to repeat the morphine in the dose of one-sixth of a grain, the atropia being omitted. This soon had the effect of modifying the pain and discomfort, and the respiration became more frequent and easy. The pulse responded but little to the stimulants. Nausea and vomiting continued at intervals of thirty minutes during the entire day and until 7 p.m., when it became less frequent, with less retching—in fact, being simply a regurgitation of the fluids of the stomach. This condition continued at longer intervals until six o'clock the following morning.

At 10 p.m. the pulse was 158, temperature 96.5, respiration 35, which was the most critical period attending the collapse. At 11:20 p.m. the evidences of reaction began to manifest themselves.

When the pulse had diminished to 120, the temperature had risen to 98 degrees F., and the respiration was 18.

The patient slept at short intervals, generally arousing with an effort at regurgitation of the contents of the stomach, but otherwise expressed a feeling of comfort and gave evidences of rest. During the night he seemed to be refreshed and was comparatively free from pain. There was no time after my first visit, up to this

period, that the patient was not perfectly rational, and often made brief, persistent inquiries as to the character of the wound and his condition.

At the evening consultation, July 2 (7 p.m.), the opinion was expressed by some of the medical gentlemen invited to the case, that internal hemorrhage had taken place, and that he would not survive the night, and expressed these views to the council. The symptoms of profound collapse were so grave that Surgeon-General Wales was induced to express the opinion that the President was dying.

All the physicians visited the White House at 8 a.m., July 3, for the morning consultation, agreeably to a previous understanding that such should be the case if the President survived the night. At this consultation, Surgeon-General Barnes and Surgeon Woodward, U.S.A., Dr. Reyburn and Dr. N. S. Lincoln visited the bedside of the patient with me, with a view of making the necessary examinations, dressing the wound, and of reporting results to the other members of the council. The patient was found with a pulse of 115; the temperature was nearly normal, as was the respiration. He was cheerful, gave evidence of being rested, and made definite inquiries regarding his condition and prospects. The use of morphine hypodermically, in doses of sufficient quantities to control the pain in the extremities, was advised, and it was agreed that the patient should continue to occupy the position on his right side as before directed, so far as was possible; and that the wound should be exposed only when the dressings became disarranged; and that their character should not be changed.

The primary reaction reached its highest point of temperature, pulse, and respiration, at 2 p.m. on Sunday, July 3. Slight tympanites was detected, but no pain on pressure, or any marked rigidity of the abdominal walls. These were the only symptoms which pointed to the existence of peritonitis throughout the whole course of the case, and the spontaneous movement of the bowels, already noted, was an additional evidence that the peritoneum was not involved.

At 10:45 p.m. the pulse had gradually increased in frequency until it reached 120. The temperature remained at 100 degrees, and respiration at 20. At this time Dr. D. Hayes Agnew of Philadelphia and Dr. Frank H. Hamilton of New York were summoned to visit the patient in consultation. Dr. Agnew arrived about four o'clock the following morning, July 4, and Dr. Hamilton at 6 a.m. They were presented to the President formally at the consultation, 8:15 a.m., at which time the pulse was 104, temperature 99.4 degrees, and respiration 19. He had passed a comparatively comfortable night, awakening every twenty or thirty minutes, taking water or liquid nourishment in small quantities each time and dropping quickly to rest. The nausea had quite subsided, and the pain and soreness of the lower extremities was measurably controlled by the administration of morphia, which was continued in quarter-grain doses each evening, administered hypodermically.

A careful review of the case from the time I first saw the President was given to these gentlemen, with the request that they, with the data before them, examine the case thoroughly, as though it were their own, and freely express their views of the character and gravity of the injury and the course of treatment of the case up to that time. I also gave them a detailed account of the explorations made in the wound and the unsettled convictions as then held as to the course of the missile and the organs involved in the injury. They individually examined the wound with great care. These examinations consisted in the introduction, in different directions, of probes, flexible bougies, in order, if possible, to determine the course of the ball. With the evidences developed by this personal examination, together with the complete history of the shooting of the President, and the progress of the symptoms for the first forty-seven hours, they proceeded to discuss the possible course of the ball and organs involved, viz., whether it passed directly forward into or through the liver, or was deflected backward at a right angle so as to involve the spinal column, or downward behind the peritoneum toward the pelvic cavity. Carefully weighing all the evidences, the more prominent symptoms upon which the diagnosis was based are presented in the following manner: the relative position of the assassin to the President at the time of shooting, the direction of the ball through the tissues, so far as safe exploration could determine, gradual subsidence or modification of pain and hyperaesthesia of the feet; the repeated unsuccessful efforts to pass a probe or flexible instrument more than one-half inch in any direction, beyond the fractured rib, except in a direction downward, a little forward and anterior to the twelfth rib, a distance of about two inches. The fact also was considered that explorations had twice been made with the finger—one by myself soon after I reached the injured President, and subsequently by Surgeon-General Wales of the Navy, on the occasion of the consultation on the evening of July 2; and in each instance it was found impossible to successfully explore by that means beyond the inner border of the fractured rib so as to determine, with accuracy, the course of the ball, or even the condition of the tissues indicated by the end of the finger. Nor did they underestimate the significance of the profound shock, nor the unusual period of collapse which followed and seemed to point to extensive lesion of important viscera. However, that the kidneys, intestine, and peritoneum were not immediately involved, was made patent by the unrestrained passage of normal urine at proper intervals, the spontaneous movement from the bowels of natural faeces, the frequent discharge of flatus, and the absence of other symptoms of peritonitis. With all these facts before them it was impossible to determine positively the course taken by the ball. The indications pointed to a downward course of the ball, into the pelvic cavity. Upon careful consideration of the foregoing facts, and of the opinions

expressed by the distinguished counsel, we were inclined to recede from the opinion at first adopted regarding the supposed passage of the ball through the liver. The propriety of making extensive incisions and dissections so as to explore the fractured ribs and remove as much as might be necessary to reveal the true course of the ball, was duly considered. But the opinion was maintained that favorable progress of the President thus far did not warrant any interference, and, further, such an operation would seriously complicate the case and diminish the prospects of recovery. The facts revealed by the autopsy cofirms the wisdom of the course pursued. With this in view all the surgeons concurred.

The case progressed, with slight fluctuations, up to July 23, when a rigor occurred at 7 p.m. followed by a pulse of 124, respiration 26, and temperature 104 degrees F. Two days previous to this a pus-sac was observed in the common integument extending down below the twelfth rib toward the erector spinae muscle, and underneath the latissimus dorsi and was carefully evacuated by gentle pressure into the original opening on the occasion of each dressing. We did not feel satisfied that this superficial and limited collection of pus, which was so readily evacuated, was the principal cause of the aggravation of the symptoms present. However, a free incision was made into the pus sac, which afforded a more direct and dependent channel to the fractured rib, from which a small fragment of bone was removed.

After the operation the improvement was not as prompt as we had reason to expect, and on the 26th of July the opening between the fractured ends of the eleventh rib was enlarged, and a small detached portion was removed. This facilitated the discharge of pus, and, as a result, a more uniform condition of the symptoms was maintained until about August 6, when slight febrile exacerbations were observed, which continued to be manifest until the operation was made to afford a more free passage of pus from the supposed track of the ball. The necessity of the operation was more plainly developed by passing a flexible catheter through the opening previously made, which readily coursed toward the crest of the ilium, a distance of about seven inches. This cavity was evacuated twice daily, by passing through the catheter, previously inserted in the track, an aqueous solution of permanganate of potash from a small hand-fountain, slightly elevated, the water and pus returning and escaping at the opening externally. The indications for making a point of exit in the dependent portion of the pus-sac were urgent, and on August 8 the operation was performed by extending the incision previously made, downward and forward through the skin, subcutaneous fascia, external and internal oblique muscles, to a sinus or pus-channel. The exposed muscles, to a sinus or pus-channel, contained a considerable number of minute spiculae of bone. Upon carrying a long, curved director through the opening between the fractured rib downward to the point of incision, there was a deeper channel which had not been exposed by the operation thus far, and the incision was carried through the transversalis muscle and transversalis fascia, opening into the deeper track and exposing the end of the director. A catheter was then passed into the portion of the track below the incision, a distance of three and one-half inches, and in a direction near the anterior superior spinous process of the ilium. The President was etherized during this operation.

On August 18 a slight tumefaction of the right parotid gland was noticeable, unaccompanied by pain or tenderness on pressure, until the suppurative period was established, when mental disturbance, vomiting, restlessness, and jactitation supervened; nor was there any increase of temperature, local or systemic, to indicate the probability of its metastatic origin. The parotitis presented many of the characteristics of an ordinary carbuncle, and was unaccompanied by any other abscesses in the adjoining tissue. During the progress of the parotitis facial paralysis occurred, and continued with slight improvement, until the time of his death. When the climax of suppuration was reached, a free discharge of laudable pus followed, with a rapid abatement of the more urgent symptoms, and after the separation of the slough (which was limited in extent) reparation was rapid and complete throughout the entire suppurating surface, as well as in the several incisions which had been previously made to liberate the pus.

The subject of the removal of the President to a more salubrious locality had been discussed for several days, and was urgently presented at the consultation on August 25. The majority of the council, with myself, considered that his removal at this time would be attended with very great hazard. The hope, however, was expressed that the President might be sustained until suppuration was established in the parotid, and the constitutional disturbances incident thereto had subsided, when it would be possible to remove him.

Finally, it was decided by the majority of the surgeons that the President should be removed to the seashore.

His transfer from the Executive Mansion to the cars was made with the least possible disturbance, without accident, and with perfect satisfaction and comfort to the patient. During the journey his pulse and temperature were taken from time to time, and frequent examinations made to determine the effect of the motion at different rates of speed. The minimum of unpleasant motion seemed to be secured at a rate of about sixty miles an hour. During the last hour of his journey he showed symptoms of fatigue, which would have prevented a longer journey, had such been required to reach his destination. His pulse increased, the countenance became slightly anxious, and the temperature measurably exalted at the period to which I allude.

He was transferred from the cars to the Elberon cottage at 10 p.m. without accident. His pulse at 10 p.m. reached 124, temperature 101.6 degrees. The morning of September 7 his pulse had fallen to 106, temperature 98.4 degrees, respiration 18. The President expressed great satisfaction that he had arrived at the seashore, and notwithstanding the heat of the two succeeding days, it made but little impression upon the distinguished patient, the pulse, temperature, and respiration continuing the same until September 15, when his pulse slightly increased in the evening, so that it occasionally reached 120 during the night.

After his arrival at Elberon there was an extension of the bronchial catarrh into the ramifications of the bronchi of the right lung, and limited broncho-pneumonia followed.

I should mention here a fact well known, that the President was so much pleased with his improvement, that he expressed that the number of his professional attendants should be reduced. Accordingly, Drs. Barnes, Woodward and Reyburn retired from the case, leaving Elberon the morning of September 8.

September 17, at 11:00 a.m. a severe rigor occurred of half an hour's duration, followed by a sharp rise of temperature. At 12 a.m. the pulse was 120, temperature 102 F., and respiration 24. The mental disturbances were more noticeable during the febrile rise, but the stomach was able to retain the nourishment and stimulants, which were given at regular intervals in the form of milk punch. This chill was accompanied by severe pain over the anterior mediastinum, and the President said to me that it was similar to what he understood as angina pectoris. It is evident that this pain, which occurred on several occasions at intervals of six to twelve hours prior to his death, was occasioned by first, a rupture of the aneurismal sac, and the progressive dissection, at irregular intervals, of the blood into the surrounding tissue, until finally it burst into the peritoneum.

A febrile rise was very marked by twelve noon of the 17th, attended with great anxiety of countenance, the temperature falling to 98 degrees F., the lowest point of normal range, the pulse being, however, steadily at 102, and rather feeble. While there was, in my judgment, an absence of typical metastatic abscesses to produce this symptom, there was a profound expression of gravity in his condition that was not commensurate with the systematic disturbance, and which prevented my absence even for a few moments at a time. I made the remark to Dr. Agnew: "I am in constant fear of some danger impending. We may have a terrible outburst, possibly in the shape of a cardiac thrombus," I said to members of the family: "There is a gravity in this case that portends serious trouble."

At 6:00 p.m. of the 18th there was another chill, accompanied with pain as before. The febrile rise continued until midnight, the pulse varying from 112 to 130.

At 8:00 a.m., September 19, the pulse was 106 and feeble; temperature 108.8, and all the conditions unfavorable. In half an hour afterward there was still another chill, followed by febrile rise and sweating, and also with pain as before. During the periods of chill and fever he was more or less unconscious. He passed all day in comparative comfort, and at 8:30 in the evening his pulse was 108, respiration 20 and temperature evidently a little lower than normal.

At 10:10 p.m. I was summoned hastily to the bedside, and found the President in an unconscious and dying condition, pulseless at the wrist, with extreme pallor, the eyes opened and turned upward, and respiration eight per minuate, and gasping. Placing my finger upon the carotid, I could not recognize pulsation; applying my ear over the heart, I detected an indistinct flutter, which contiuued until 10:35, when he expired. The brave and heroic sufferer, the nation's patient, for whom all had labored so cheerfully and unceasingly, had passed away.

Autopsy revealed the track of the ball presenting a course of entrance downward and forward to the point of impingement upon the eleventh rib, and being then deflected to the left at almost a right angle, passing behind the kidney, perforating the intervertebral cartilage and first lumbar vertebrae anterior and to the left of the kidney, and finding its lodgment below left extremity of the pancreas, wounding in its track the splenic artery.

A mass of black, coagulated blood covered and concealed the spleen and the left margin of the greater omentum. On raising the omentum it was found that this blood-mass extended through the left lumbar and iliac regions and dipped down into the pelvis, in which there was some clotted blood and rather more than a pint of bloody fluid.

The blood coagula having been turned out and collected, measured very nearly a pint. It was now evident that secondary hemorrhage had been the immediate cause of death, but the point from which the blood had escaped was not at once apparent.

The adhesions between the liver and the transverse colon proved to bound an abscess-cavity between the under-surface of the liver, the transverse colon, and the transverse mesocolon, which involved the gall bladder, and extended to about the same distance on each side of it, measuring six inches transversely and four inches from before backward. This abscess did not involve any portion of the substance of the liver except the surface with which it was in contact, and no communication could be detected between it and any part of the wound.

The liver was larger than normal, weighing eighty-four ounces; its substance was firm, but of a pale yellowish color on its surface and throughout the interior of the organ, from fatty degeneration. No evidence that it had been penetrated by the bullet could be found, nor were there any abscesses or infarctions in any part of its tissue.

The spleen was connected to the diaphragm by firm, probably old, peritoneal adhesions. There were several rather deep congenital fissures in its margins, giving it a lobulated appearance. It was abnormally large, weighing eighteen ounces; of a very dark lake-red color both on the surface and on section. Its parenchyma was soft and flabby, but contained no abscesses or infarctions.

Behind the right kidney, after the removal of that organ from the body, the dilated track of the bullet was dissected into. It was found that from the point at which it had fractured the right eleventh rib (three and one-half inches to the right of the vertebral spines) the missile had gone to the left, obliquely forward, passing through the body of the first lumbar vertebra and lodging in the adipose connective tissue immediately below the lower border of the pancreas, about two and one-half inches to the left of the spinal column, and behind the peritoneum. It had become completely encysted.

The track of the bullet between the point at which it had fractured the eleventh rib and that at which it entered the first lumbar vertebra was considerably dilated, and the pus had burrowed downward through the adipose tissue behind the right kidney, and thence had found its

way between the peritoneum and the right iliac fascia, making a descending channel which extended almost to the groin. The adipose tissue behind the kidney in the vicinity of this descending channel was much thickened, and condensed by inflammation. In the channel, which was found almost free from pus, lay the flexible catheter introduced into the wound at the commencement of the autopsy; its extremity was found doubled upon itself, immediately beneath the peritoneum, reposing upon the iliac fascia, where the channel was dilated into a pouch of considerable size. This long descending channel, now clearly seen to have been caused by the burrowing of pus from the wound, was supposed during life to have been the track of the bullet.

On the examination and the dissection made, it was found that the fatal hemorrhage proceeded from a rent, nearly four-tenths of an inch long, in the main trunk of the splenic artery, two and one-half inches to the left of the coeliac axis. This rent must have occurred at least several days before death, since the everted edges in the slit in the vessel were united by firm adhesions to the surrounding connective tissue.

The surgeons assisting at the autopsy were unanimously of the opinion that, on reviewing the history of the case in connection with the autopsy, it is quite evident that the different suppurating surfaces, and especially the fractured spongy tissue of the vertebra, furnish a sufficient explanation of the septic conditions which existed during life.

The autopsy report was signed by Drs. D. W. Bliss, J. K. Barnes, J. J. Woodward, Robert Reyburn and D. S. Lamb. The names of Drs. F. H. Hamilton, D. Hayes Agnew, and A. H. Smith, were not appended to it. It was, however, submitted to them, and they gave their assent to the other portions of the report.

The body of President Garfield was taken back to the Capitol where it lay in state in the rotunda for two days and then was taken to Cleveland, Ohio, for burial in the Lakeview Cemetery. Among the great numbers in attendance at the cemetery was Major William McKinley, who later became President McKinley, and who, himself as President, met a similar fate at the hands of an assassin.

The assassin, Charles Guiteau, was captured before he could escape from the scene and placed in jail. Following Garfield's death, he was tried by the court in Washington, D. C., and found guilty, and later executed by hanging.

Many prominent alienists, or psychiatrists, were called at that time to testify as there seems to have been some question as to whether or not Guiteau had a mental illness. He was a strange, ne'er-do-well, fanatical sort of character, fairly well educated, had practiced law, I believe in Chicago, and engaged in various other occupations, even the ministry. He had conceived the idea of being made a consul to France, and had been in Washington for some time, amongst the hoard of office seekers, and, having been disappointed, followed the President at various times, even to church, with intent to assassinate him.

The late Dr. Alan McLane Hamilton, alienist of New York City, and distantly related to Alexander Hamilton, was at the trial of Charles Guiteau and gave an excellent description of it in his book.

The doctors who cared for President Garfield, one feels, in reading the history, were men of character and high standing, and great professional ability. Dr. Hayes Agnew was, perhaps, the most outstanding of the group. He was a great surgeon of the Listerian period, and was professor of surgery at the University of Pennsylvania.

Dr. Frank Hamilton was a great orthopedic and plastic surgeon of New York City.

When I first started treating fractures on the Iron Range of Northern Minnesota, we sometimes used the Hamilton splint.

We must recall that their difficulties in treating the gunshot wound of President Garfield were much greater than ours would be at the present day. It was before the days of aseptic surgery, antiseptic or Listerian surgery was practiced. There was no x-ray to assist in diagnosis. There was no penicillin nor sulfa drugs, no antibiotics, no antitoxins, blood transfusions nor intravenous solutions. Today, we would likely not probe for a bullet or even insert the finger for examination. No sterile surgical gloves were in use until Professor Halsted of Johns Hopkins used them in the early Nineties.

In 1900, when I interned at St. Luke's Hospital, Saint Paul, Minnesota, rubber gloves were in constant use by Drs. Wheaton and McLaren, and all the younger surgeons, John T. Rogers, Warren Dennis, Judd Goodrich, Harry Ritchie, Arthur Gillette, Knox Bacon, Alexander Colvin, and other younger men who operated at St. Luke's hospital. Yet there were excellent older surgeons over the country who did not use gloves, and operated bare-handed, with arms exposed to the elbows, for a number of years after 1900.

It would seem that one must conclude that sepsis entered largely into the cause of the death of President Garfield, even though a sudden hemorrhage seemed the immediate cause.

(Continued on Page 258)

SPONTANEOUS PNEUMOTHORAX COMPLICATING BRONCHIAL ASTHMA DUE TO WOOD DUST

J. S. BLUMENTHAL, M.D., F.A.C.P.
Minneapolis, Minnesota

IN spite of the increased intra-alveolar pressure present in asthma, an associated spontaneous pneumothorax has been infrequently reported. This is the more remarkable because this entity is not an uncommon event in apparently normal chests, even with the individual at rest. Thus Crenshaw[4] reports on eighty-six patients between the ages of a few hours and seventy-two years in whom spontaneous pneumothorax occurred in the absence of tuberculosis or trauma, while severe exertion was a contributing factor in only a few. This rarity of reported spontaneous pneumothorax in asthma may be because the increased pressure in asthma comes in inspiration in alveoli that have become gradually dilated. It may also be because the diagnosis is missed because of the difficulty in detecting the new physical findings and symptoms in the presence of already marked asthmatic and emphysematous signs, even though the breathing may be further embarrassed. Persistent nonexpansion of the lung is quite rare. Crenshaw[4] reports ten of eighty-six cases with persistent spontaneous pneumothorax due to labor and segmental localized emphysema with formation of bullae and blebs. At any rate, pneumothorax is frequently found at autopsy in asthmatics[7] even though it may be unsuspected clinically. The cause of pneumothorax is probably the rupture of blebs and bullae due to increased size because of tension or because of interference with the blood supply to the bleb.

Spivacke[14] reported a case of asthma with pneumothorax in an eleven-year-old child, though other pathological factors may have been involved. Faulkner and Wagner[6] report a case of fatal spontaneous pneumothorax and subcutaneous emphysema in an asthmatic. Jeffrey and Marlott[8] report on a bilateral pneumothorax in a seventeen-year-old asthmatic. Perhaps because of greater ease in diagnosis, subcutaneous emphysema associated with or without pneumothorax is more frequently noted.[2,5,11,13] The underlying cause is essentially the same except that, of course, the lung vesicles rupture under thhe visceral pleura.

The treatment of simple and single spontaneous pneumothorax is usually conservative but exploratory thoracotomy in persistent types may be indicated.

Wood[1,3,9,10,12,15] has been known to cause allergic manifestations. Kejaat, boxwood, orangewood, pine, spruces, cedar are among the woods involved, though at times the many smuts and fungi are very difficult to rule out. Skin tests may or may not be positive though clinical tests are. Treatment by desensitization is usually successful, but avoidance of the allergen is, of course, usually the method of choice.

Case Report

A carpenter, aged forty-three, was admitted to the University Hospital with symptoms of five days' duration. He had a cough, shortness of breath, pain of sudden onset in the right chest and a "sloppy" sensation in the right chest. The cough and shortness of breath had also suddenly become much more severe five days ago. There is no history of any unusual exertion, but he had had a cough with asthmatic breathing for the last nine months which was initiated and aggravated at his place of employment. His symptoms were only present after being exposed to the dust at his place of work. This dust consisted of oak, mahogany and cedar woods. No previous history of asthma could be elicited. His past and family history are not contributory.

Physical examination was negative except for chest findings. There was a flatness of the right intercostal spaces; the right supraclavicular fossa was shallow. There were decreased breath sounds and fremitus in the same area. The trachea was shifted to the left. X-ray revealed a massive pneumothorax of the right chest. The cardiac and tracheal shadow was shifted to the left indicating a tension pneumothorax. The right dome of the diaphragm was depressed. Respirations were 26, pulse 78, blood pressure 110/70, temperature 98. The eosinophile count was 15 per cent though the count had been normal on several previous occasions. Other findings were not remarkable. Intradermal skin tests were for the most part negative but the mixture of cedar, mahogany and oak dust from his place of work produced

From the Department of Internal Medicine, Allergy Clinic, University of Minnesota.

a positive scratch test. While an atomizer inhalation of house dust was productive of no clinical symptoms, when wood dust was used the patient had definite signs of respiratory embarrassment. Because of the odor of the cedar, it was difficult to disguise the material used. Extensive questioning did not reveal any antipathy to his work, employers or surroundings. It would be difficult to escape the conclusion that the wood dust was the antigen causing the asthma. The factor of the spontaneous pneumothorax is very difficult to assess.

The patient was treated conservatively except that the air in the pneumothorax was aspirated twice in the first twenty-four hours. He made an uneventful recovery and at the last visit had no symptoms. He was advised to refrain from exposure to the antigen as the most practical form of treatment though desensitization could be considered.

Summary

A case is reported of spontaneous pneumothorax in a man suffering from asthma probably caused by wood dust.

References

1. Bahn, K.: Contribution to the question of allergy in wood-sawers. Klin. Wchnschr., 7:1963, 1928.
2. Chester, Samuel W.: Subcutaneous emphysema complicating chronic bronchial asthma. Ann. Allergy, 7:783, (Nov.) 1949.
3. Cobe, H. M.: Sensitivity due to Christmas trees. J. Allergy, 1:442, 1930.
4. Crenshaw, G. L.: Etiology, treatment and surgical indication of non-tuberculous, non-traumatic spontaneous pneumothorax. Dis. Chest, 17:369, (Apr.) 1950.
5. Elliott, R. W.: Subcutaneous emphysema and pneumothorax in bronchial asthma. Lancet: 1: 1104, 1938.
6. Faulkner, W. B., Jr., and Wagner, R. J.: Fatal spontaneous pneumothorax and subcutaneous emphysema in an asthmatic. J. Allergy, 8:267, 1937.
7. Feinberg, Samuel: Allergy in Practice. P. 429. Chicago: Year Book Publishers, 1944.
8. Jeffrey, G. S., and Marlott, D. C.: Simultaneous bilateral spontaneous pneumothorax complicating broncial asthma. Canad. M.A.J., 39:171, 1938.
9. Marken, L. E.: Boxwood sensitiveness. J. Allergy, 1:346, 1930.
10. Ordman, D.: Wood dust as inhalant allergen. South African M. J., 23:971, (Dec.) 1949.
11. Rosenberg, L., and J.: Subcutaneous emphysema complicating bronchial asthma. Am. J. M. Sc., 195: 682, 1938.
12. Schonvald, P.: Discussion in allergy. J. Allergy, 1:87, 1929.
13. Sheldon, J. M., and Robinson, W. D.: Subcutaneous emphysema in asthma. J.A.M.A., 107:1884, 1936.
14. Spivacke, C. A.: Asthma with pneumothorax. M. J. & Rec., 122:10, 1925.
15. Walker, I. C.: Bronchial asthma. Oxford Med., 2:128, 1937.

THE FUTURE OF THE VETERANS ADMINISTRATION MEDICAL PROGRAM

(Continued from Page 220)

happy to serve, often at considerable personal sacrifice, as advisers and consultants. The medical and nursing staffs of Veterans Administration hospitals were brought to a par with the best civilian institutions, equipment was improved, opportunities for research were created and the veteran was provided with "medical care second to none."

All this was not accomplished without a struggle. As Dr. Carroll points out, there is much that has been criticized. No system is without fault, and the inherent defect in the Department of Medicine and Surgery in the Veterans Administration is that it is subject to the restrictions, regulations and budgetary limitations that affect the entire Veterans Administration Program. Consequently, its personnel, its supplies and equipment and even its planning may be impaired by measures directed primarily toward abuses in other departments of the Veterans Administration. This defect was recognized at the outset by General Hawley. Complete rapport between him and General Omar Bradley minimized the problem, but with the departure of these men to other fields, the difficulties have slowly multiplied. Without warning, extensive reductions in personnel have been ordered, with results often deleterious to the care of patients; personnel ceilings have been established when certain hospitals were already seriously shorthanded thus permanently crippling their staffs; minimal expenditures that would permit the development of research programs have been forbidden, while millions of dollars were being spent to erect hospitals where they were not badly needed.

Recognizing these defects, Dr. Magnuson has vigorously championed the cause of a more independently administered medical program. Under his leadership, substantial progress has been made in effecting affiliations between medical schools and the Veterans Administration hospitals. He has attracted the highest type of medical personnel to the Veterans Administration, and under him the best and most modern treatment of the incapacitated veteran has been assured. His insistence that the administration of hospitals and clinics should be under the direct control of the chief medical director has received the complete and unwavering support of his board of national consultants. Any deviation from his policies undoubtedly will bring about a deterioration in the medical program of the Veterans Administration. His loss is a grievous one; his successor assumes a momentous responsibility for the future of the program.

Fortunately, the appointment of Vice Admiral Joel T. Boone as chief medical director indicates that there will be no change in policy and no acceptance of lower standards. Admiral Boone, a holder of the Distinguished Service Cross and the Congressional Medal of Honor, a naval officer of distinction and a man of the highest personal integrity, is well equipped to maintain the high ideals and high standards of medical care originally envisaged by Generals Bradley and Hawley. In his efforts he will have the wholehearted support not only of his colleagues within the Veterans Administration but of the entire medical profession.

The ultimate future of the Department of Medicine and Surgery in the Veterans Administration, however, depends upon whether or not it is granted the autonomy it needs to manage its hospitals and clinics in accordance with the best medical traditions.—*Editorial, New England Journal of Medicine*, Feb. 8, 1951.

History of Medicine In Minnesota

MEDICINE AND ITS PRACTITIONERS IN OLMSTED COUNTY PRIOR TO 1900

NORA H. GUTHREY
Rochester, Minnesota

(Continued from the February issue.)

On November 20, 1884, William J. Mayo was married to Hattie May Damon, of Rochester, the daughter of Eleazer Damon and Carolyn M. Damon. Mr. and Mrs. Damon were both of English descent and natives of Massachusetts who came to Rochester in 1856. Mr. Damon was the pioneer jeweler of the city; his first store was a small log building on what is now First Avenue, S. W.; the path that led westerly from the store to his home became Zumbro Street. He was a good citizen who furthered all measures for the welfare of city and county; the family were sustaining members of the Congregational Church. With the marriage of William J. Mayo and Hattie M. Damon there began a perfect companionship, in an always gracious home, that was to continue fifty-five years. Those who have enjoyed the hospitality of Dr. and Mrs. Mayo in their home or on their boat on the Mississippi River know well the restful order and friendly atmosphere that surrounded them. Five children were born to Dr. and Mrs. Mayo, three daughters and two sons, of whom the sons Worrall William and William Damon and one daughter Helen Phoebe died in infancy. Dr. Mayo's deep affection for his family, his pride in them and his loyalty to them were a vital influence in his life.

In his first year as a physician W. J. Mayo began his faithful reading of medical journals and his frequent trips for postgraduate study and observation, first to Chicago and New York and soon to all parts of the United States and Europe, wherever he heard of men who were doing surgical work that was new or good or courageous. There are in the files of the Mayo Clinic the little notebooks he kept on those trips. The entries usually begin with city, date and hospital, the operating surgeon, his personal appearance and, sometimes, his mannerisms; the list of names is a roster of the world's great surgeons from 1883 into the early nineteen hundreds. Most of the notes are in pencil, a few in ink, occasionally made clearer by a crude sketch, and they concern preoperative care and postoperative care of patients; hospital routine, "for the Sisters"; technique of operations in all fields of surgery; and operating room equipment, including improvisations. An example is a memorandum made at the surgical clinic of Dr. W. S. Halsted, of Baltimore, in 1895, on the use of rubber gloves and rubber-soled shoes in the operating room, and of towels as aprons for quick changes at the operating table.

Even before he entered practice William J. Mayo was introduced by his father to organized medicine, at meetings of county, district and state societies; and once at a meeting of the American Medical Association, where he heard Dr. John L. Atlee, of Philadelhia, in tribute to his late great brother, Dr. Washington L. Atlee, and felt in accord with him in fraternal loyalty. As a young physician a little later Dr. Mayo occasionally attended a medical meeting in company with Dr J. B. McGaughey or Dr. Franklin Staples of Winona, for both of whom he always

had affectionate and grateful regard because of their early kindly interest and encouragement; as he had for Dr. Nathaniel S. Tefft, of Plainview, who once saved him from error in a treatment that he was carrying out in youthful enthusiasm.

In 1883 he became a member of the Minnesota State Medical Society, in 1885 he helped to reorganize the Olmsted County Medical Society, in 1892 he became a member of the American Medical Association and in that year was a founder of the Southern Minnesota Medical Association. In the state group, as noted earlier, he served at various times on committees, was the first vice president in 1891, second vice president in 1892, and in 1893, the youngest man, until then, to hold the office, he was elected president. In 1899 he became a fellow of the American Surgical Association, on the proudest day of his professional life; in 1885 he had attended a meeting of the association, a young country doctor, and had thought wistfully of the glory of membership; in 1913-1914 he was the society's president. He was president of the American Medical Association in 1905-1906; the Society of Clinical Surgery, 1911-1912; American College of Surgeons, 1918-1919-1920; Congress of American Physicians and Surgeons, 1925; and the Interstate Postgraduate Medical Association of North America, 1932-1933. On his election to the presidency of the American Medical Association, Rochester honored him, his brother, who had just been elected president of the Minnesota State Medical Association, and his father, much as the city had honored Dr. W. W. Mayo in 1904, and presented Dr. W. J. Mayo with a three-handled silver loving cup on which was engraved, "Presented to Dr. W. J. Mayo by his many Rochester friends, July 24, 1905."

He early realized the importance of writing medical papers and of presenting them before scientific groups. In formal writing and formal public speaking he employed literary English concisely and effectively. Otherwise he used the vernacular and used it well. His custom in preparing a paper was to begin with an arresting sentence, follow it with text that required, except on rare occasion, not more than fifteen minutes for reading or delivery, and a cogent summary. He agreed with the old preacher who said, "Few souls are saved after the first fifteen minutes of a sermon."

At various times Dr. W. J. Mayo was a member, either health officer or secretary, of the Rochester Board of Health. From 1892 to 1900 he served on the Minnesota State Board of Health; when he resigned, in January, 1900, Governor John Lind appointed Dr. Charles H. Mayo to the vacancy.

By 1905 his list of society memberships, honorary degrees, medals and awards already was impressive, but it was only a fraction of what it was to be. In Portland, Oregon, in that year, when Dr. William L. Rodman, of Philadelphia, nominated Dr. Mayo for unanimous election as president of the American Medical Association he said, in small part, and informally: "At no one time, in no one place, has the complete list of the honors, degrees and memberships received by Dr. William J. Mayo been published, and this at his expressed wish. Not in lack of appreciation, he was deeply grateful to all who honored him, but because he felt that to make public as an authorized publication the world-wide list would savor of too much self-esteem." This was true of Dr. Mayo all his life. Honors that came to him he accepted as meant equally for his brother and the clinic as a whole.

For his service during World War I, as noted earlier, Dr. Mayo received the Distinguished Service Medal. On June 30, 1917, he received a letter from Surgeon-General William C. Gorgas of the War Department asking him to act as surgical adviser in General Gorgas' office and to select such men as he thought best in the surgical profession of the United States to act as his associates. Major Mayo accepted and on July 9, 1917, took up his duties. His first act was to secure

the appointment of his brother, Dr. Charles H. Mayo, as alternate. Together they chose their associates. Throughout the war, as colonels, they served as alternating chief consultants; when one was in Washington, the other was in Rochester. Their official function was to insure and to maintain, as far as possible, the proper standard of character and professional ability of the physicians taken into the medical service of the army and to plan and carry out ways and means for their special training.

Dr. William J. Mayo began his medical and surgical practice officially on July 1, 1883; on July 1, 1928, he performed his last surgical operation. He turned quietly from the work he loved to apply himself to other professional endeavor in which he believed at sixty-seven he would be more useful. In his first years of practice he operated in every field then known. He did early and original work on cicatricial stricture of the esophagus. His first thyroidectomy, in 1890, in which Dr. C. H. Mayo was his assistant, was his last. After Dr. Charlie's surgical versatility became manifest, Dr. Will centered his attention on abdominal and pelvic surgery. His safe and simple method of overlapping repair of umbilical and postoperative abdominal hernias came into general use. His work in the field of liver, gallbladder and biliary ducts and pancreas is well known. He made enduring contributions in studies of the physiology and anatomy of the large intestine, rectosigmoid and rectum in relation to radical operations on these organs, and in surgery of the kidney, ureter and genital tract. His studies of diseases of the uterus and adnexa, with early standardization of abdominal myomectomy for the pregnant and the nonpregnant uterus, demonstrated the desirability of myomectomy over hysterectomy for the patient in the childbearing period. He is best known for his standardization of surgery of the spleen as related to operations for removal of the spleen for diseases of the blood and other conditions; for intensive studies of duodenal ulcer and gastric ulcer and for surgical procedures for their cure and prevention; and for perfecting radical operations for the curative removal of carcinoma of the stomach.

His keen intelligence and sensitive intuition made Dr. W. J. Mayo a rare judge of character and ability, an exceptional leader. He recognized opportunity and foresaw occasion; so delicately did he impart recognition and foresight that the recipients never became aware that certain new ideas on which they acted were not originally their own. Because of his seniority in the clinic he forced himself, outside the circle of family and close friends, to be impersonal, at sacrifice of the camaraderie that he would have enjoyed and that he missed. It has been said that he had too great dignity, too much reserve, that he was inflexible in his decisions. He was immovable only when there were in question professional integrity and the honorable progress of the clinic and the foundation on a basis of justice to all. In such matters of high obligation he accepted misunderstanding. His kindly tolerance was not a gift bestowed at birth, but was of gradual growth, the flowering of self-discipline and self-control.

With gradually changing economic conditions he recognized the need for change in the administration of the clinic. He saw depression coming years ahead and tried to prepare for it by preparing the members of the staff both as to mental attitude and as to financial safeguarding. His last twenty years were given largely to evolving and bringing into effect, in co-operation with able associates and advisers, basic principles for functioning of the clinic and the foundation. To this end he left his major funds, guarding carefully against suggestion of rule by the dead hand.

There remains uppermost in the memories of the many physicians who came

under Dr. Will's teaching when they were green recruits, his kindness to young doctors, his understanding, his praise of all that could be praised, his few and always friendly corrections free from criticism. To a new and frightened assistant in the operating room who before an operation was reviewing the clinical data for him, he would say, "Remember, you are the architect, I am only the carpenter."

Of his compassionate understanding much is known, much cannot be told, because the telling would renew for many the pain of old sorrow and trouble through which Dr. Will sustained them or from which he rescued them. He restored courage and self-respect.

A member of the Episcopal Church, he was in active sympathy with the work of all denominations and valued the aid of the clergy in ministering to the sick. To needy and anxious patients he was doubly a life-giver, for by quietly relieving their financial worries he gave them increased chance for recovery. He used to say, "I understand and sympathize with the common man—the intelligentsia who are educated beyond their intelligence, I do not understand." And, on refusing certain high offices, "I want to be a plain, everyday doctor, holding the respect and esteem of the medical profession."

He was grateful for the recognition he received from the medical profession. He felt privileged to serve as a regent of the University of Minnsota from 1907 until his death. He had deep satisfaction in the usefulness of the clinic and in the realization of the Mayo Foundation for Medical Education and Research, which fulfills his supreme purpose of furthering better care of the sick. In his last weeks, lying where he could see the Mayo Foundation House, his former home, he had comfort in the knowledge that the house was fulfilling Mrs. Mayo's and his hope when they gave it, in August, 1938, that it would "become a meeting place where men of medicine may exchange ideas for the good of mankind."

When Dr. Mayo returned home in April, 1939, after spending the winter in Arizona, it was to undergo a clinical examination that resulted in discovery of a gastric lesion of the type to the surgical palliation or cure of which he had made major contributions. When he had looked at the x-ray picture, he spoke simply of the diagnosis and gave his own prognosis. His death occurred on July 28, 1939. Two days before he died he said, accepting the end with the calm spirit with which he had accepted all inevitable and unchangeable things, ". . . I have no regret except in the personal sorrow my going will bring. . . . It has been given to me more than to most men to realize my dreams." He had loved the truth and sought to know it.

In 1949 there survived Dr. William James Mayo, all of Rochester, Mrs. Mayo; two daughters, Carrie Louise Mayo, wife of Dr. Donald C. Balfour, and Phoebe Gertrude Mayo, wife of Dr. Waltman Walters; and nine grandchildren and fourteen great-grandchildren. Dr. D. C. Balfour, with the Mayo Clinic since 1907, is professor of surgery, the Mayo Foundation, Graduate School, University of Minnesota, and director (beginning October, 1947, emeritus director) of the Mayo Foundation. Dr. Waltman Walters, with the Mayo Clinic since 1920, is head of a section on surgery in the clinic and is professor of surgery, the Mayo Foundation. During World War II he served as captain in the Medical Corps of the United States Navy, in naval hospitals in the United States and at Aiea Heights, Hawaii.

Charles Horace Mayo (1865-1939), sixth child and younger son of Dr. and Mrs. William Worrall Mayo, was born in Rochester, Minnesota, on July 19, 1865.

Charles H. Mayo received his preliminary education in the common schools and the high school of Rochester, his early intensive training in premedical and medical subjects under his father, and practical experience in chemistry and pharmacology in a local drugstore during vacations. In September, 1885, he matriculated for a course of three years at the Chicago Medical College (the medical department of Northwestern University), a school known for its wealth of clinical material, its fine department of clinical and research laboratories, and its distinguished faculty. Here he came under the influence of Nathan S. Davis, John H. Hollister, Frank Billings and William E. Casselberry in medicine and under Edmund Andrews, John E. Owens and Ralph N. Isham in surgery, Walter Hay in nervous and mental diseases and Oscar De Wolf in state medicine and public hygiene, and others. After graduation on March 27, 1888, he returned home to begin practice with his father and his brother. On April 6, 1888, he received his Minnesota state license No. 23 (R). In the following year he made the first of his many trips abroad and on his return took his first formal post-graduate work, at the New York Polyclinic Medical School and Hospital, for which he received an ad eundem degree. Thereafter his trips for study were annual, so that the *Rochester Post* commented: "Dr. 'C. H.' keeps up with the times. Neither he nor his brother Dr. 'W. J.' lets any new method for improvement of practice pass unheeded or unlearned."

On April 6, 1893, Charles H. Mayo was married to Edith Graham, of Rochester, a sister of Dr. Christopher Graham and one of the thirteen children of Mr. and Mrs. Joseph Graham, pioneer settlers of Olmsted County. In notes on Dr. Graham (*q.v.*) in this article is included a brief history of this unusual family. Edith Graham, a graduate of the Woman's Hospital of Chicago in 1889, was the first trained nurse in Rochester and the first instructor in nursing and anesthesia at St. Mary's Hospital. After a few months in the home of Dr. and Mrs. W. J. Mayo, while their own house was rising next door, Dr. and Mrs. C. H. moved into their Red House; in 1912 they removed to Mayowood, a few miles from town. The hospitality of their home became traditional; Dr. Mayo was an inimitable host, Mrs. Mayo a hostess of rare tact and vivacious charm. They became the parents of eight children, Margaret, Dorothy, Charles William, Edith, Joseph Graham, Louise, Rachel and Esther, of whom Margaret and Rachel died in infancy; they had one adopted daughter, Marilyn, and a foster son, John Nelson. Dr. Charlie was happiest when his family were about him, as they always were when he was at home.

The outstanding qualities of Charles H. Mayo were his capacity for friendship, his sympathetic understanding of and approach to the common man, his catholicity of interests, his resourcefulness and ingenuity as a surgeon. Dr. Morris Fishbein said of him, "He was a man who understood how to talk to all mankind and who knew how to convey the story of medicine in its best way."

Genial, kindly, responsive to friendliness, for his own fullest enjoyment Dr. Mayo needed a group about him and the more varied the better. So diverse and so numerous were his interests and talents that life was endlessly fascinating to him. Student of books though he was, one who knew him well has said that he learned more from observation and listening than he did from study. He had the gift of gleaning from his travels not only useful

scientific knowledge but innumerable interesting and amusing impressions, of social customs, art, music, architecture, government and what not. As a conversationalist and as a public speaker he had a charm all his own, a sense of humor that triumphed over the most formal occasion. When assigned a set subject, although he treated it with due consideration, he would interpolate remarks on many unrelated subjects, to the delight of his hearers and to his own enjoyment.

His mechanical ingenuity, which became of such great service in surgery, was an inherent gift. When he was a young boy, he could tinker toy engines successfully and repair deficiencies in household equipment; he constructed a workable telephone between home and his father's office. When St. Mary's Hospital was built, he designed and helped to install a hydraulic elevator, which was serviceable although it had a peculiarity that the designer could not then obviate: the apparatus could be operated only from inside the car, so that when the elevator had been left at an upper floor and was needed on a lower floor, someone would have to climb the stairs and bring it down. Dr. Mayo designed the first operating table used in the hospital, and devised superior surgical instruments, among them dissecting scissors, curved and straight.

A surgeon of exceptional skill and scientific discernment, he made contributions of enduring value in many fields of surgery, and originated operative procedures. In his earlier professional years he operated for cataract and for conditions of bones and joints. His method of operation for bunion came into general use. His anterior transverse open operation for suppuration of the knee joint met adoption in cases of the type in which amputation formerly had been practiced. He was early to operate successfully for brain tumor and for trigeminal neuralgia; one of the first to devise operations to relieve nerve compression by removal of supernumerary (cervical) ribs. He evolved a surgical technic to improve circulation of the blood in cranial skin grafts. He introduced an easy and ingenious method of vein stripping, one of the early procedures of surgical treatment for varicose veins, and designed an instrument for performing the operation. He advocated and used surgical treatment for arteriovenous aneurysms. In dealing with carcinoma he advocated and practiced removal of carcinoma and with it the associated lymph nodes at primary operation rather than waiting until the nodes were involved. He was early in devising operations for carcinoma of the tongue, cheek and jaw; and he brought to popular medical attention the two-stage exteriorization operation for carcinoma of the colon. To surgery of the urinary tract he contributed successful implantation of the ureters into the sigmoid (adaptation of the experimental method of Coffey) in the human patient for congenital exstrophy of the bladder; he developed the transperitoneal operation to open the bladder for removal of vesical tumors. He perhaps is best known for his researches on exophthalmic goiter, with Drs. H. S. Plummer, W. M. Boothby and E. C. Kendall, in working out the causation and frequency of the disease, methods of preliminary medical treatment and surgical procedures; his theory and practice have resulted in early diagnosis and cure in a high percentage of cases.

He had an almost uncanny ability to see possibilities of surgical treatment and to devise and adapt new operations. This facility was well known to his fellow surgeons, so that in 1914, when the American Surgical

Association met in Rochester, the visitors wanted to put it to the test. They asked Dr. Will, "Can't you pick out a case Charlie has not seen, a patient who has been operated on unsuccessfully two or three times and for whom little or nothing can be done surgically?" Dr. W. J. Mayo chose for presentation at the surgical clinic a patient who had been operated on seven times elsewhere and whose condition apparently was beyond surgical relief; the visiting surgeons saw the woman and agreed on the uselessness of further surgical intervention, and they were prepared to see Dr. Charlie baffled. When he was called in, he looked at the results of previous operations and whistled in dismay; then, to the visitors' amazement, he outlined an entirely new plan of operative procedure and carried it out successfully—and with lasting benefit to the patient.

Dr. C. H. Mayo did meritorious work toward the organization and functioning of medical societies, county, district, state, national and special. In 1888 he became a member of the Olmsted County Medical Society and of the Minnesota State Medical Society, and thereafter in the state group served at various times on committees, as censor, as chairman of the section on surgery and, in 1905-1906, as president. The great medical and surgical organizations of the country conferred presidency upon him: the Western Surgical Association, in 1904-1905; Society of Clinical Surgery, 1911-1912; Clinical Congress of North America, 1914-1915; American Medical Association, 1916-1917; American College of Surgeons, 1924-1925; Chicago and Northwestern Railway Surgical Association, 1927-1928; American Surgical Association, 1932-1933; Minnesota Public Health Association, 1932-1934; Interstate Postgraduate Medical Association of North America, 1934-1935. He was an active member of numerous other medical societies and of many groups devoted to the arts and sciences and to economic, civic and social welfare, and served on many committees and boards of trustees of those organizations. The list of his memberships, honors, medals and awards is extraordinarily comprehensive. He accepted such honors as meant for his associates as much as for himself. His record in Masonry was exceptional. His distinguished military record was discussed earlier in this paper. He was a supporting member of the Episcopal Church.

Dr. Mayo was actively interested in education of youth, and particularly in the extension and improvement of the public schools of Rochester. He was vice president of the city school board from May 15, 1915, to March 15, 1923. In this period he was influential in establishing in Rochester the junior college, the first junior college in the state, which gives the first two years of the university course. Enthusiastic about the Boy Scouts of America, he served as a member of the National Council and on committees of health and safety. In June, 1932, he became a trustee of Northwestern University and of Carleton College.

(To be continued in the April issue.)

President's Letter

FOR THE NINETY-EIGHTH TIME

For the ninety-eighth successive year, the Minnesota State Medical Association will meet in scientific, social and sports sessions—carrying on a tradition of professional and personal fellowship that has contributed to this state's reputation as an outstanding medical center.

This year the meeting is being held in Rochester, April 30, May 1 and 2, with business sessions beginning on Saturday, April 28. The Council and the House of Delegates will be considering important policy developments for the coming year and will hear reports on Committee work during 1950.

The Committee on Scientific Assembly has prepared a scientific program, especially designed to fit into busy schedules of practicing physicians and keyed to subjects of most general and current interest. Six topics will occupy the three-day session: Monday, April 30. "Fractures" in the morning and "New Drugs" in the afternoon; Tuesday, May 1, "Pulmonary Diseases" in the morning and "Acute Abdominal Conditions" in the afternoon; Wednesday, May 2, "Cardiac and Peripheral Vascular Diseases" in the morning and "Allergy" in the afternoon.

Dr. Wendell G. Scott, Associate Professor of Clinical Radiology, Washington University School of Medicine, St. Louis, Missouri, will present the Russell D. Carman Memorial Lecture; and Dr. Paul W. Schafer, Professor of Surgery and Chairman of the Department of Surgery, University of Kansas School of Medicine, Kansas City, Kansas, will give the Arthur H. Sanford Lectureship in Pathology.

Golf and skeet and trap shooting tournaments have been planned for Sunday, April 29, with attractive prizes and the Pfunder and Smith trophies to lure sportsmen.

Many groups are planning special dinners and luncheons—the Minnesota Chapter of the American Academy of General Practice, the Minnesota Medical Foundation and Alumni, the Minnesota Chapter of the American College of Chest Physicians, the Minnesota Radiological Society, the Northwestern Pediatric Society—to name a few.

It's a meeting that no physician can afford to miss—whether he is seeking knowledge, recreation or fellowship. Tear April 30, May 1 and 2 out of your professional calendar and plan to be there when the 98th annual convention of the Minnesota State Medical Association opens.

J. F. Norman

President, Minnesota State Medical Association

Editorial

AMERICAN MEDICAL EDUCATION FOUNDATION

MOST medical schools are in more or less financial difficulties due to a number of factors—the increase in costs due to inflation, diminished returns from investments and the end to the support of medical students by the Federal Government.

How can the income of medical schools be increased? Certainly not by increased tuition. There is little prospect of a return of the days when large bequests were obtainable from wealthy individuals. To the proposal that the Federal Government be called upon to subsidize the medical schools, the answer of the medical profession is "No." Government subsidy means government control, according to a U. S. Supreme Court ruling. As an indication of how strongly the medical profession feels about the importance of medical schools maintaining their independence of the Federal Government, the Board of Trustees of the AMA appropriated a half-million dollars to establish what is to be known as the American Medical Education Foundation to accept funds to be used to support the hard-pressed medical schools of the country. The action of the Board of Trustees was unanimously approved by the House of Delegates of the AMA in December.

Physicians are urged to contribute, not a mere token contribution, but $100 per member if possible. Contributions of $100 have been coming in to the AMA office from individual members since the day following the announcement of the establishment of the fund. The California State Medical Association sent in a check for $100,000 for its members from the Association's reserves.

It is estimated that in the neighborhood of $10,000,000 will be needed yearly by the medical schools to maintain them in their present efficient status. Funds should be available this spring, and members are therefore urged to send in contributions promptly. Every physician has received more from his medical school than he paid in tuition. It is true that some physicians have paid back in services rendered to their Alma Maters, in some instances manyfold. Some have already made generous contributions to their Alma Maters and should not be expected to contribute to the American Medical Education Foundation.

While medical schools can be readily classified as publicly or privately owned, when the source of their operating funds is considered, the distinction is not so sharp. Publicly owned schools in many instances rely heavily on endowments and current gifts from private sources; on the other hand, privately owned schools receive some financial aid from city, state or federal tax funds. It is therefore entirely consistent with the existing pattern of medical school support that the National Fund for Medical Education not discriminate between publicly and privately owned institutions. No restrictions, also, are to be attached to the contributions to medical schools.

Contributions, both small and large, should be sent to the American Medical Education Foundation, 535 North Dearborn Street, Chicago 10, Illinois. Contributions are, of course, deductible for Federal income tax purposes.

THE AMERICAN ACADEMY OF GENERAL PRACTICE

ON MAY 1, 1946, a small group of Minneapolis physicians met to initiate an association of general practitioners. Up to that time, there was no local organization which those in general medical and surgical practice could call their own. As far as this writer knows, there was no such association anyplace in the country at that time.

A large number of specialty groups have been formed over a period of many years, and additional groups are still being formed. These groups were organized for mutual benefit and general fellowship, as well as for specific promotion and advancement of these various specialties. The individuals in each group found that their problems were similar and that their aims followed the same general path. It was natural that many common ties would bind these in-

dividuals into a cohesive group. It was likewise natural that those who have a common interest in the general practice of medicine should wish to have their own organization.

After the Minnesota group—then known as the American College of Physicians and Surgeons—began to make headway, other similar organizations sprang up in other parts of the country. It was inevitable that these groups of similar purpose would unite in one larger organization, national in scope. Thus it was the American Academy of General Practice came into being in 1947. The Minnesota group was absorbed February 1, 1948.

In addition to this sketchy account of the organizational background of the American Academy of General Practice, it might be well to dwell briefly on this group's aims and purposes. At the outset, it should be pointed out that this is not an "anti-specialists" association or a "gripers" organization. In the very beginning some of the cohesiveness of the local group was motivated by indignation over staff regulations in some of the hospitals. In the main, the causes for complaints and dissatisfactions have been eliminated, and the Academy's primary concern now is the building up of that great segment of the medical profession—the general practice group. The Academy's purpose is that of mutual fellowship—its paramount aim, the betterment of the general practice of medicine.

The American Academy of General Practice publishes its own journal—the "G.P." This is conceded to be a very fine publication. The editor is the inimitable Dr. Walter Alvarez. The organization sponsors an excellent annual meeting and encourages postgraduate study in the interim by giving credits for such study. The American Academy of General Practice also has issued a manual on the establishment of Departments of General Practice in Hospitals. The principles expressed therein have been incorporated in the "Manual on Hospital Standardization" of the American College of Surgeons.

It is only natural that the older, more established medical organizations would look with some suspicion at this new organization during its early development. The American Academy of General Practice is now definitely past its infancy and gives every promise of robust growth and stable character.

The Editorial Staff of MINNESOTA MEDICINE feels that it voices the feeling of the membership of the Minnesota State Medical Association in again affirming* its confidence in the American Academy of General Practice and in wishing the Academy and its publication "G.P." every success.

BILL S.1, SECTION 23

THE SOCIALIZERS in Washington are ever on the alert to seize opportunities to involve the Federal Government in providing medical care for U. S. citizens. The serpent of socialistic governmental medical care is scotched—not killed.

The latest example is Bill S.1 recently introduced in the U. S. Senate. Section 23 of Bill S.1 authorizes the President to socialize medical care for a large segment of the population—those rejected for failure to meet the standards for physical and mental fitness established for the draft. The field involved is only vaguely related to defense. The Bill proposes to take advantage of the draft to provide medical care at the expense of the Federal Government for those rejected. While medical men would recognize that here are citizens, a portion of whom—but probably a smaller portion than most people think—have remediable defects which should be cared for, yet we ask why at governmental expense? This would be extension of state medicine for several million more citizens.

The profession is downright opposed to Bill S.1. Rejected draftees who have defects uncovered in the process of the draft should obtain medical advice on their own responsibility and, if unable to finance a medical examination and treatment, should consult one of the many facilities provided for the medically indigent. Bill S.1, if enacted, would cost the taxpayers billions, a large portion of which would be spent uselessly for disabilities beyond the power of medical science to alleviate or cure. And this Bill is proposed at a time when the country is forced to exert all its energy and resources in providing military defense and economizing in every other non-essential governmental activity. When will our lawmakers realize the seriousness of our financial condition with inflation still on the up grade and the people taxed to the breaking point?

* Editorial, General Practice and G.P. Minnesota Med., 33:715, (July) 1950.

FERTILITY IN CRYPTORCHIDS

THE ARTICLE on "Fertility in Cryptorchids" by Dr. Charles E. Rea, which appears in this issue, contains the operative results following Wangensteen's modification of the Keetley-Torek operation on eight young men with bilateral cryptorchidism.

According to the author, this report includes all his bilateral cases in which operation has been performed ten or more years ago. All eight of his subjects are married, no pregnancy has resulted, none of the testes is normal in size, and in the four tested no sperm was found on testicular biopsy.

To the unbiased reader, this would seem to be an honest admission of 100 per cent failure in the main objective of the operation—the development of a normal functioning testis by placing it in its normal position. It would seem that the author's statement, "There is no question but that the placing of an undescended testis in the scrotum allows the gonad to develop to varying degrees," requires further amplification.

Dr. Rea makes the distinction between pseudocryptorchidism and true undescended testicle as others do. The term pseudocryptorchidism is used for those cases in which the testis at times is palpable and can be pushed down into the scrotum. In the author's opinion, these are the cases in which spontaneous descent usually occurs. There is general agreement on this point. But how about the youngsters in whom upon examination the testis is not palpable? They would seem to be true cases of cryptorchidism. What percentage of these testes will fail to descend spontaneously? Just which ones will be "anatomically retained" no one can predict. That only a small percentage of these true cryptorchids —testes that cannot be palpated—will fail to descend at puberty has been contended, with considerable supporting evidence.* If the great majority of undescended testes descend spontaneously, are normal in size and therefore presumably functioning normally, there is every reason to refrain from operation. If it were a fact that only a few undescended testes descend spontaneously, still that would be a sufficient reason for refraining from operation, if operation is 100 per cent failure as indicated by Dr. Rea.

It would be of interest if other surgeons would report on their experiences with fertility in patients operated upon for bilateral undescended testes. It is in the bilateral case that it is highly important that the correct advice be given.

FEE SPLITTING STILL

IN HIS presidential address before the Ramsey County Medical Society, which appears in this issue, Dr. Warner Ogden points a finger of scornful ridicule at the surgeon who allows the referring physician to assist (?) at the operation in order presumably to justify a splitting of the fee. Most surgeons who merit the appellation have their teams of one or more assistants. The technical performance is of a much better quality as a result of the team work. An outsider who may not have assisted at an operation since his interne days and may never have really learned operating-room technique is of no real help in the performing of the operation, and the danger of disrupting his aseptic technique is not only a hazard but should be distracting to the surgeon. The would-be assistant is taking a fee which he did not earn. The surgeon, in reality, has split his fee in order to induce the referring practitioner to send him more work.

After all that has been said and written about the evils of splitting fees and the stand that has been taken by county, state, national and surgical societies, it seems unbelievable that the practice still continues. All one has to do to find out who the surgeons are who place "business" before the welfare of their patients in this manner is to peep into the operating rooms or keep his ears open in the cloak-rooms of the hospitals. The guilty ones may rest assured that their identities are well known among their confreres.

The medical societies have taken a stand on this practice. It could be stopped by the Executive Committees of the hospitals. They, therefore, share in the guilt.

---

* Johnson, William W.: Cryptorchidism. J.A.M.A., 113:25, (July) 1939. Drake, Carl B.: Spontaneous late descent of the testis. J.A.M.A., 102:759, (March 10) 1934.

MEDICAL ECONOMICS

Edited by the Committee on Medical Economics
of the
Minnesota State Medical Association
George Earl, M.D., Chairman

LEGISLATURE GETS MENTAL AID BILL

A new bill before the Minnesota state legislature, provides for the licensing of mental aids in the state. Leaders in the Minnesota mental health program favor this plan, and it has Governor Youngdahl's support, who said of it, "This plan will give incentive to our psychiatric aids. They will have a goal to strive for."

The bill would set up a five-member board to license aids, but would not make it more difficult to get workers, according to the governor. The plan would be a voluntary one—any aid who wishes to qualify may do so.

As it stands now, H. 113 requires that any person who wishes to become a registered psychiatric aid must take an examination, which would be "practical and designed to test the applicant's fitness, education, training and experience" to perform successfully the duties of a psychiatric aid.

It is felt that this bill would greatly aid Minnesota's mental health program by providing more competent people to work with the mentally ill. Experts in the mental health field have called the aid "the most important worker in the mental hospital. The aid works more closely with the patient than any other member of the hospital staff."

CONGRESS TO WEIGH NEW HEALTH BILLS

As the 82nd Congress meets amid stiff arguments and petty bickering, it finds itself confronted with many new and many old proposals concerning the health and welfare of the nation as a whole. Of the more than 1,000 bills introduced so far in the House alone, about one in every ten deals with medical care, hospitalization or some other health issue.

Among the carry-overs from the 81st Congress are: national health insurance, income tax deduction of medical and dental expenses, Federal support of school health services, income tax deduction of sums paid into prepayment health service plans, Hill-Burton Act amendments, various veterans' medical care bills, greater benefits for dependents of military personnel.

The new bills include one dealing with Federal aid to nursing education; the upholstered bills on support of local public health units; H. R. 1502, restoring the $65 million cut from this year's Hill-Burton operations; S. Res. 39, giving a two-months time extension (until March 31) to the special investigation of prepayment medical and hospital plans; H. R. 1611, establishing a National Poliomyelitis Institute; H. R. 1644, offering $100,000 a year for life, to individuals discovering "general cures" for cancer, heart disease and poliomyelitis; S. 486, enlarging utilization of Indian hospitals; and S. 513, to study injuries to health suffered by Americans who were prisoners of war.

JOURNAL CALLS BILLS "SAME OLD PACKAGE"

Looking over President Truman's slate of bills and his budget for the coming fiscal year, the *Wall Street Journal* could only call the whole thing "the same old package." No doubt the *Journal* felt, too, that the package's wrapping and ribbon—increased defense spending—was an excellent disguise with which to push through administration welfare schemes.

Checking Truman's list of proposed legislation, the *Journal* found nothing new and spectacular:

"The old, rejected Brannan farm plan in a disguised form, which by means of subsidies, would give high prices to farmers for their perishables and simultaneously low prices to the housewives.

"A government-operated and government-subsidized national medical plan.

"Expand the federal government's costly unemployment insurance program.

"Federal government subsidies for the nation's schools, including nursery schools. . . .

"And—Congress willing, of course—we should also go ahead with a general expansion of the government's power to look after our private lives, including an expansion of rent control, the adoption of a 'fair employment' law and the complete control of prices and wages."

The *Journal* exposes the flagrant disregard for economy in government at a time when the nation's economy should run smoothly:

"Behind all this program is a philosophy which says that the cost of anything or everything is a matter of no consequence whatsoever, that a government can tax as much as it will and can spend as much as it will without hurt and provide not only anything but everything at once. Hence the mere fact that a government is tripling its armament expenses need not in the least deter it from spending as many other billions as it wishes."

Congress Will "Reject" Bills

The *Journal* expresses many Americans' attitude when it states that the President's proposals are the same as his old Fair Deal package, repeatedly presented to Congress, and which Congress "just as repeatedly, has rejected . . .":

"These economic pills can be covered with a 'defense emergency' coating now. But they're pills just the same. We will expect Congress to reject them even more firmly now."

WRITER ADVISES ETERNAL VIGILANCE

Felix Morley, writing in *Nation's Business* recently, struck a warning to Americans concerning the vast national power and control which come with any national emergency declaration.

President Truman's "national emergency," coupled with his "same old package" legislation, represent a threat to American freedoms, Mr. Morley said. He felt that "the people themselves, and their elected representatives, must be on guard to prevent undue encroachments on their own rights by their own officials. And this eternal vigilance, which is the price of liberty, is doubly imperative at a time when external danger makes usurpation of power by officials seem reasonable, if not essential."

Sensing that President Truman may be trying to put something over on them by slipping Fair Deal legislation into his huge budget which includes defense legislation, Americans can agree with Mr. Morley's view:

"Although the fundamental safeguards of individual liberty continue to stand, it is obvious that the powers now assumed by the Executive constitute a potential threat to every American home. This is not less true because this centralized power is being built up to meet the threat of external aggression. Many a people have lost their freedom in the belief that they were defending it against a foreign foe. Indeed the most subtle way to destroy liberty is to argue that it is a fair-weather luxury which must be sacrificed during a period of national peril."

Americans will also agree that during a time of national peril, it is even more important for liberty to be guarded, for only a free people can best aid themselves to reduce that national peril. Conscientious citizens resent and combat the introduction of any legislation tending to threaten their fundamental liberties. They, like Congress, do not find it easy to swallow Truman's defense-legislation-coated pill because they know it contains harmful ingredients in varied ominous forms.

Mr. Morley concludes that the remedy is not to give more power to officials:

". . . the remedy certainly does not lie in granting ever more power to officials who cannot now effectively command that which is already in their grasp. It lies, rather, in restoring the balance that our forefathers wrote into our Constitution—a document which could profitably be dusted off and reread before it becomes a dead letter.

"Such re-examination would recall Madison's warning that, while the first necessity is a government that can control the governed, it is of equal importance to insure that the government shall be obliged to control itself."

SOCIALIZED MEDICINE CALLED ALIEN BLIGHT

A recent editorial in the *Seattle Post Intelligencer* applied one of the most accurate labels to compulsory health insurance that has yet been used:

"Compulsory health insurance is not an American invention. It originated in Bismarck's Reich: and it had grievously impaired German medicine long before the Nazi degradation started . . .

"The progress of medical science has been impeded, and the quality of medical service has deteriorated.

"Nonetheless, the 'social planners' want to import the alien blight of socialized medicine into this country."

Lauds Medical Profession

Praising American doctors for their crusade against socialized medicine, the newspaper said that "never before in the United States, however,

(Continued on Page 274)

✦ Reports and Announcements ✦

SECOND INTERNATIONAL POLIOMYELITIS CONFERENCE

The second International Poliomyelitis Conference will be held at Copenhagen, Denmark, September 3 to 7, 1951. This will constitute the first formal meeting of the International Poliomyelitis Congress. Mr. Basil O'Connor is president of the Congress, and the National Foundation for Infantile Paralysis and the Danish National Association for Infantile Paralysis will sponsor the Congress. Dr. Niels Bohr is president of the Conference.

Governments are invited to send representatives to the Conference, and invitations are also sent to universities and scientific institutions as well as to scientists and doctors. The four official languages will be English, Franch, German and Spanish, and simultaneous interpretation into each of the three languages not being used at the moment will be made, just as at the United Nations.

The *M.S. Stockholm* of the Swedish-American Lines will sail from New York on August 25, arriving at Copenhagen on September 2. Reservations for sailing are to be made through Thomas Cook & Son, 587 Fifth Avenue, New York 17, N. Y.

AMERICAN GOITER ASSOCIATION

The 1951 meeting of the American Goiter Association will be held in the Deshler-Wallick Hotel, Columbus, Ohio, May 24, 25 and 26.

The program for the three-day meeting will consist of papers dealing with goiter and other diseases of the thyroid gland, dry clinics and demonstrations.

MICHAEL REESE HOSPITAL POSTGRADUATE SCHOOL

The Michael Reese Hospital Postgraduate School is offering a one-week course in "Clinical Dermatology—Refresher Course in Diseases of the Skin for General Practitioners." This full-time, intensive course will meet from April 2 to April 7. Clinics and lectures will be conducted by the members of the Department of Dermatology and Syphilology.

The school is also offering a one-week course in "Surgery—Indications, Pre-operative and Post-operative Care" from April 9 to 14. Clinical and didactic material in this full-time course will be presented by members of the Department of Surgery and co-operating departments.

A two-week course will also be offered in "Recent Advances in Internal Medicine." This full-time, intensive course will meet from April 30 to May 12. Clinical and didactic material pertaining to recent advances in diagnosis and therapy will be presented by members of the Department of Internal Medicine, other clinical departments and the Division of Laboratories and Research. For further information, address: Dr. Samuel Soskin, Dean, 29th St. and Ellis Ave., Chicago 16, Illinois.

CRIPPLED CHILDREN SERVICES

1951 Spring Clinic Schedule

Place	*Date*	*Building*	*Counties*
St. Cloud	March 31	Technical High	Stearns Benton Sherburne
Thief River Falls	April 7	High School	Pennington Marshall Red Lake Roseau Kittson
Austin	April 14	Central High School	Mower Freeborn Dodge
Faribault	April 21	High School	Rice Goodhue, Carver Dakota, Waseca Steele, Scott
Grand Raids	April 28	Senior High	Itasca Cass
Detroit Lakes	May 5	High School	Hubbard Mahnomen Becker Clay
Brainerd	May 12	Franklin Jr. High	Crow Wing Wadena Mille Lacs Todd Cass Aitkin
Worthington	May 19	Grade School	Nobles Jackson Pipestone Cottonwood Murray Rock
Moose Lake	May 26	High School	Aitkin Carlton Pine Cook, Lake
International Falls	June 2	Alexander Baker Sch.	Koochiching Lake of Woods
Morris	June 9	High School	Stevens, Grant Traverse, Pope Douglas Big Stone

MINNESOTA SOCIETY OF NEUROLOGY AND PSYCHIATRY

The regular meeting of the Minnesota Society of Neurology and Psychiatry was held in Saint Paul on March 13.

The scientific program included the following:

"A Clinical Evaluation of Carotid-Jugular Anastomosis in Mental Deficiency; a Report of Ten Cases" by Dr. Ivan Baronofsky, Dr. J. W. Bussman, Audrey Stenberg, and Dr. Reynold A. Jensen.

"Drug Therapy in Parkinsonism," inaugural thesis, by Dr. Sidney K. Shapiro.

CLARENCE M. JACKSON LECTURE

Dr. Carl E. Badgley, professor of surgery at the University of Michigan, delivered the annual Clarence M. Jackson lecture at the University of Minnesota on March 1. The title of his address was "Fractures about the Hip—Early and Late Therapy."

The program, which was open to the public, is sponsored each year by Phi Beta Pi medical fraternity as a memorial to Dr. Jackson, former head of the University's anatomy department who died in 1947.

(Continued on Page 252)

(Continued from Page 250)

MINNEAPOLIS ACADEMY OF MEDICINE

Dr. John A. Haugen was elected president of the Minneapolis Academy of Medicine at the annual meeting of the organization on February 19. Other officers include Dr. Donald C. MacKinnon, vice president; Dr. Chauncey N. Borman, secretary, and Dr. U. Schuyler Anderson, recorder.

HENNEPIN COUNTY SOCIETY

President-elect of the Hennepin County Medical Society is Dr. William R. Jones, who will succeed Dr. Reuben F. Erickson as president next October. Vice presidents include Dr. Reuben A. Johnson and Dr. James B. Carey. New members of the board are Dr. Robert F. McGandy and Dr. Silas C. Andersen.

McLEOD COUNTY SOCIETY

Election of officers was held at the annual meeting of the McLeod County Medical Society in Glencoe on January 18. Dr. L. L. Kallestad, Brownton, was elected president of the group, succeeding Dr. Arthur Neumaier of Glencoe. Dr. J. D. Selmo, Norwood, was named secretary-treasurer.

RAMSEY COUNTY SOCIETY

New officers of the Ramsey County Medical Society were installed at a meeting of the group in Saint Paul on January 29. President is Dr. F. G. Hederstrom; secretary-treasurer, Dr. Laurence Hilger, and president-elect, Dr. J. P. Medelman.

RICE COUNTY SOCIETY

At the annual meeting of the Rice County Medical Society on January 16, Dr. C. A. Traeger, Faribault, was elected president of the organization. Other officers named include Dr. R. F. Mears, Northfield, vice president, and Dr. J. J. Kolars, Faribault, secretary-treasurer.

Dr. Heinz Bruhl, Faribault, Dr. R. H. Buesgens, Waterville, and Dr. Guy Walter, Farmington, were accepted into membership in the society. The membership now totals thirty-five.

WASECA COUNTY SOCIETY

At a meeting of the Waseca County Medical Society in Waseca on January 16, Dr. S. C. Oeljen was elected president of the organization. Also named to office were Dr. G. E. Olds, vice president, and Dr. Anthony Ourada, secretary-treasurer.

WINONA COUNTY SOCIETY

Dr. Paul Heise was elected president of the Winona County Medical Society at its meeting in Winona on January 8. He succeeded Dr. H. J. Roemer in the office.

Other officers named included Dr. L. F. Johnston, vice president; Dr. H. R. Schmidt, secretary, and Dr. W. O. Finkelnburg, treasurer.

(Continued on Page 254)

Have you tried the Aerohalor

in treating

secondary invaders

of the Common Cold?

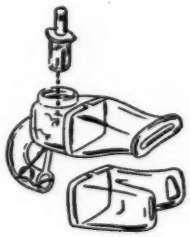
Let us make this point clear at the beginning. We do not recommend penicillin powder inhalation therapy with the AEROHALOR as a cure for the virus cold. It is not. But Krasno and Rhoads[1] have some interesting observations:

"The course of ordinary colds is strikingly shortened by prompt use of the penicillin dust inhalation. We have no illusions that it is effective against virus that initiates the common cold or any other viruses."

The authors also report: "We are fully aware that the etiologic agent of the common cold is probably not a penicillin-sensitive organism. Secondary invaders undoubtedly account for the accentuation of the initial symptoms and in most instances for the more serious complications. Dramatic results often are seen in those patients in whom the cold has been hanging on."

As to the therapeutic effectiveness of inhaled penicillin dust, Krasno and Rhoads state "with assurance" that "bacterial infections of the nasopharynx, para-nasal sinuses, nasal mucosa, larynx and trachea of fairly recent origin, respond well to this form of treatment."

The smoke-it-like-a-pipe therapy afforded by the AEROHALOR is convenient and effective. For the complete story, write for comprehensive literature to Abbott Laboratories, North Chicago, Illinois. Abbott



Aerohalor®

(ABBOTT'S POWDER INHALER)

AEROHALOR comes assembled with detachable mouthpiece. Easily interchangeable nosepiece included in package. Disposable AEROHALOR* Cartridge containing 100,000 units of finely powdered penicillin G potassium is prescribed separately—three to an air-tight vial.

*Trade Mark for Abbott Sifter Cartridge. AEROHALOR and AEROHALOR Cartridge patented in U. S. and Foreign Countries.

1. Krasno, L., and Rhoads, P. (1949), The Inhalation of Penicillin Dust; Its Proper Role in the Management of Respiratory Infections, Amer. Prac., 11:649, July.

(Continued from Page 252)

CONTINUATION COURSES

Urology.—The University of Minnesota announces a continuation course in urology to be presented at the Center for Continuation Study on April 2 to 6. The course is given under the sponsorship of the North Central Section of the American Urological Association. Dr. C. D. Creevy, professor of surgery and head of the Division of Urology, is faculty chairman for the course.

Distinguished visiting physicians who will participate are Dr. Hugh J. Jewett, Baltimore, Maryland; Dr. Lloyd G. Lewis, professor, Department of Urology, Georgetown University Medical School, Washington, D. C.; Dr. Reed M. Nesbit, professor and chief, Department of Urology, University of Michigan Medical School, Ann Arbor; and Dr. Parke G. Smith, professor and head, Department of Urology, University of Cincinnati, Cincinnati, Ohio.

Lupus Erythematosus.—A postgraduate symposium on lupus erythematosus will be presented at the Center for Continuation Study, April 5 and 6. The symposium is intended especially for doctors specializing in dermatology and internal medicine. A cordial invitation is also extended to general physicians.

Distinguished visiting physicians who will participate include: Dr. John R. Haserick, Cleveland, Ohio; Dr. Paul Klemperer, Mount Sinai Hospital, New York; and Dr. Louis J. Soffer, assistant clinical professor, Department of Medicine, Columbia University, New York City.

The remainder of the faculty will be made up of members of the staff of the University of Minnesota Medical School and the Mayo Foundation. The course is given under the direction of Dr. Henry E. Michelson.

Gynecology.—A continuation course in gynecology will be presented April 9, 10, and 11 at the Center for Continuation Study of the University of Minnesota. The course is intended for general physicians and will emphasize problems of the menopause, uterine myomas, and benign ovarian tumors. Dr. H. C. Hesseltine, professor of obstetrics and gynecology, University of Chicago, will be the visiting faculty member for the course. The course is presented under the direction of Dr. John L. McKelvey, head of the Department of Obstetrics and Gynecology.

Proctology.—The University of Minnesota announces a continuation course in proctology to be presented at the Center for Continuation Study on April 16 through 21. The course is intended for doctors of medicine who are engaged in general practice and surgery. Throughout the course emphasis will be placed upon those anorectal and colonic lesions most frequently seen by practicing physicians. The presentation will be by means of lectures, operative clinics, motion pictures, and seminars. Guest faculty member for the course will be Dr. Robert A. Scarborough, associate professor of surgery, Stanford University Medical School, San Francisco, California. The remainder of the faculty for the course will be made up of clinical and full-time members of the staff of the University of Minnesota Medical School and the Mayo Foundation.

Electrocardiography.—A continuation course in electrocardiography will be presented by the University of Minnesota on May 7 to 11. The course is intended for general physicians and will be presented at the Center for Continuation Study. Dr. George E. Burch, professor and chairman, Department of Medicine, Tulane University of Louisiana, New Orleans, and Dr. Harry E. Ungerleider, medical director of research, the Equitable Life Assurance Society, New York City, will be the visiting faculty members for the course. In addition, Dr. Burch will give the first annual George E. Fahr Lecture on May 8. This lecture is, of course, presented for all physicians and students who are able to attend.

Minnesota Multiphasic Personality Inventory.—A continuation course on the Minnesota Multiphasic Personality Inventory will be presented for general physicians at the Center for Continuation Study on May 14 by the University of Minnesota. The mechanism, interpretation, and clinical use of the test will be discussed.

The immediate need in the control of cancer is for more accurate early diagnosis and to accomplish this desired result there must be offered to the general practitioner more active co-operation with detection centers.

The surgical biopsy still holds first place for accuracy in diagnosis. It is readily available for all extrinsic lesions and whenever possible should be relied upon for the final opinion.

Woman's Auxiliary

MID-WINTER BOARD HEARS DEFENSE SPEAKER

Mrs. Charles W. Waas, President

It is difficult to select a date for the board meeting which will be satisfactory to all, but when January 29 was planned, it was hoped that Minnesota might be enjoying its "January thaw" at that time, and it was thought that the fifth Monday of the month would not conflict with any regular meetings members might have. However, the "January thaw" did not appear. Nevertheless, thirty-nine members braved the weather and attended a very enjoyable and a very interesting meeting.

The subject of cancer played an important part on the program at the Workshop meeting in the fall. At the Mid-Winter Board Meeting civilian defense was the topic, and a most interesting discussion was given by Paul Wilson, a member of St. Paul's Civil Defense Committee. This was followed by an educational film concerning precautions and methods of protection which every citizen must follow in case of an atomic bomb attack. The film was commented upon by Colonel Paul Calder.

There were splendid reports given by various chairmen and county presidents. It is regrettable that the weather made it impossible for so many to attend. It would be profitable to all county presidents to get in communication with any of the state chairmen who might be able to help them with their particular problems. The women who are serving in this capacity are outstanding and they will be very happy to help. Please do not hesitate to write to your president, if there is any help she can give.

SAMPLE DRUGS STILL NEEDED

Mrs. B. E. O'Reilley, Chairman
Committee on Medical and Surgical Relief

Undoubtedly, auxiliary members have started collecting sample drugs, discarded instruments, medical textbooks and journals from their husbands' offices, and packing them for shipment overseas.

Mr. Pedro Velasco, President, Philippino Relief Organization, 3009 Ewing Avenue North, Robbinsdale, Minnesota, will be pleased to accept any number of boxes of drugs and materials. He will repack the drugs and pay the freight charges from Robbinsdale to the Philippines. Mr. Velasco is very enthusiastic about the auxiliary's offer to send drugs—also instruments, books and journals—as his organization is trying to equip a hospital recently built in Manila. Boxes of drugs will also be sent to dispensaries in the Provinces. Boxes of drugs (no books or journals), may be sent to the Medical and Surgical Relief Committee, Inc., 420 Lexington Avenue, New York 17, New York, for shipment overseas.

This is an excellent opportunity for members to do a very worth-while charitable work as drugs are badly needed and will be very much appreciated.

AUXILIARY WATCHES LEGISLATIVE ACTION

Mrs. L. R. Scherer, Legislative Chairman

With both federal and state legislative bodies now in session, doctors' wives should be interested in, and alert to the bills affecting the medical field either directly or indirectly.

Members can watch daily papers to check on the status of Minnesota bills, and can learn which ones the American Medical Association favors on a national basis, with the reasons for their objections to those they disapprove.

The last few years have proven that when information and facts are given to the people, public opinion is formed that is still effective. However, to be effective, the law makers must be made aware of the wishes of the people. Therefore, members should (1) continue to inform themselves; (2) work with other organizations to spread that information; and (3) write to Congressmen and ask others to write also.

If members do these things, they will be participating as good citizens to preserve freedom and democracy at home, during this period of world crisis.

AUXILIARY AIDS OLDSTERS GROUP

The Saint Paul Auxiliary, Ramsey County Medical Society, is supporting a special project in developing an expanded program of leisure time activity for the aged at Capitol Community Center, 190 E. 15th Street, Saint Paul. This center is a Community Chest agency and services a downtown neighborhood, which, because of its age and location, has within it many social problems.

The area has a high incidence of older people living within a short distance of the Center's location. Most of these people are living by themselves in rooming houses and are receiving Old Age Assistance. There are no community facilities in the neighborhood to provide a program for them. The Community Center's program for the aged began in 1947, and has never expanded because of the lack of staff to visit the oldsters and recruit them. The Auxiliary's grant will provide money for a staff leader who will not only give direct leadership, but will make home visits in an effort to get the older people to come.

The Oldsters Group meets every Wednesday afternoon at the Center from 1:00 to 3:30 p.m. While there is an active and varied program consisting of table games, Bingo, crafts, parties, singing and folk dancing, their main emphasis is on chatter and refreshments, to which they eagerly look forward. They also observe birthdays and have monthly parties. The project is designed not only to provide a place where oldsters can come, but to revive their latent and dormant skills and feeling of self-possession, which many of them have long lost. Personal service, in the way of health and case work

(Continued on Page 258)

AUXILIARY AIDS OLDSTERS GROUP

(Continued from Page 256)

referrals, is also a part of the program, and the worker spends some time having individual chats with several of the older people who indicate their desire for it.

The staff includes Mrs. Eleanore Felker, supervisor; Mrs. Robert Dunning, volunteer assistant leader; and Russell Lind, group leader and home visitor.

In addition to financial support, the Auxiliary will help with leadership at special events and with volunteer drivers to help get oldsters who are non-ambulatory, to and from meetings.

MESSAGE FROM COMMITTEE CHAIRMAN

Mrs. John J. Ryan, 2153 Iglehart, Saint Paul, chairman of the In Memoriam Committee requests that all county presidents report to her as soon as possible the names of deceased members to be remembered at the memorial service at the annual meeting of the State Auxiliary. This meeting will be on Tuesday, May 1, Rochester Country Club, Rochester, Minnesota, in conjunction with the annual meeting of the Minnesota State Medical Association, April 30, May 1 and 2, in Rochester.

ASSASSINATION OF GARFIELD

(Continued from Page 233)

We still have sepsis in gunshot wounds, but we are much better equipped to control it than were our professional brothers of Garfield's time. It would seem that the President might well have recovered in our time. This is no reflection upon Garfield's doctors, who, according to the record, gave the most meticulous and scientific care to the President possible in their time.

Honorable James G. Blaine gave the memorial address for President Garfield before Congress on February 27, 1882. He closed with these words:

"As the end drew near, his early craving for the sea returned. The Stately Mansion of Power had been to him the wearisome hospital of pain, and he begged to be taken from its prison walls, from its oppressive, stifling air, from its homelessness. Gently, silently, the love of a great people bore the pale sufferer to the longed-for healing of the sea. To live or die as God should will, within the sight of its heaving billows, within the sound of its manifold voices; with wan-fevered face, he looked out wistfully upon the ocean's changing wonders, on its far sails, whitening in the morning light, on its restless waves rolling shoreward to break and die beneath the noonday sun, on the red clouds of the evening, arching low to the horizon, on the serene and shining pathway of the stars. Let us think that his dying eyes read a mystic meaning which only the Rapt and Parting Soul may know. Let us believe that in the receding world he heard the great waves breaking on a farther shore, and felt already upon his wasted brow the breath of the Eternal Morning."

SURVIVAL OF THE FITTEST

There are those who, looking at the high maternal mortality and morbidity statistics of the Negro minority in the United States, are inclined to shrug it off with the belief that it is due to "degeneration, a manifestation of imperfect physical development or to simple racial inferiority." Dr. Leonard Goodman, Obstetric Surgeon to the Gold Coast Colony in British West Africa, pointed out at the recent International Obstetric Congress that the American Negro originally sprang from this part of the world. "The slaves from the Western world were mainly derived from tribes in the North and sold to coastal potentates who resold them to the masters of the ships that awaited them." Comparing the American Negro, however, with his native counterpart in Africa, Dr. Goodman is much impressed with the physical superiority of the American Negro. He attributes this in part to the Darwinian principle of the survival of the fittest. "The voyage in a densely crowded and insanitary vessel put these qualities to the greatest test," he said, "and those who eventually landed on this soil must have been the most robust specimens of this race, and no doubt the physical degree of development to be seen in the American Negro of today owes much to this terrible method of selection."

Dr. Goodman notes some similarities, however. The pelves of the native women in Africa are very small, he finds, 20 to 25 per cent smaller than the averages for English or white American women. This, he points out, is also true of more than 20 per cent of American Negro women. While the contracted pelvis occurs much more frequently as a racial characteristic in the black than in the white, he adds that operative delivery is much more frequently required among white women.

"Most European visitors to Accra are impressed by the small size of the pelvis and are astonished at the relative ease of delivery," he says. "Fortunately, our babies are small by English or American standards, but there is also little doubt that the fetal head can withstand extreme degrees of molding more easily than can the white baby."—*Briefs*, Vol. XIV, No. 6.

The school bell must ring each term for butcher and baker, for doctor and lawyer. He who does not constantly enrich his mind with new knowledge may find eventually that his capacity for forgetting will leave little of value behind. And no dog, however old, need ever say that he can learn no new tricks. The doctor, wherever his path may lie, can still emulate to some degree Chaucer's clerk of Oxenford, for "—gladly wolde he lerne, and gladly teche."—Editorial, *The New England J. Med.*, Nov. 9, 1950.

Meets every requirement for all diathermy technics... the GE INDUCTOTHERM

FROM diathermy treatment of the ear to that of a pelvis or chest — the GE Inductotherm meets the most exacting clinical approval. Brings you the practical, the efficient, the easy means for obtaining the desired quality and intensity of energy indicated for proper treatment.

As for output, the Inductotherm has the capacity to elevate the temperature in any region of the body to the limit of the patient's tolerance. The perfect answer to fulfill your needs over the *entire range* of modern diathermy technics.

Ask your GE representative for more details about the Inductotherm — or write

GENERAL ELECTRIC X-RAY CORPORATION

Direct Factory Branches:
MINNEAPOLIS — 808 Nicollet Avenue
DULUTH — 3006 W. First Street

Resident Representatives:
DETROIT LAKES — Eric Nelson, North Shore Dr.
MANKATO — J. F. Van Osdell, 123 Blue Earth
ST. PAUL — R. H. Holen, 153 W. Robie
SIOUX FALLS — H. L. Norlin, 1908 S. Sixth Avenue

In Memoriam

KARL DEDOLPH

Dr. Karl Dedolph was born in Saint Paul on May 15, 1887. He was the son of Dr. Fredrick Dedolph, an early member of the Ramsey County Medical Society, whose picture is still preserved in one of the early groups, namely 1889.

Doctor Dedolph's primary education was all accomplished in Germany, his father having sent him there for this training. He then returned and graduated from Mechanic Arts High School in 1905. He graduated from the University of Minnesota in medicine in 1911. He was a member of Alpha Kappa Kappa medical fraternity. From 1911 to 1912, he served as intern at Ancker Hospital. In 1913, he practiced medicine in Roberts, Wisconsin, but after six months there, he returned to Saint Paul and established himself at the corner of Snelling and Selby Avenues. He maintained his office there until the time of his death, June 8, 1950.

From October, 1913, to October, 1915, he served as City Physician under Dr. Ancker. During World War I, he served in the Medical Corps for one and one-half years at Fort Omaha and Camp Travis, San Antonio, Texas.

After the war, he returned to his Saint Paul office and carried on his general practice. He was associated with the Wilder Charities and did faithful service there for twenty-five years.

Doctor Dedolph was always closely associated with the Ramsey County Medical Foundation of Ramsey County and worked diligently to build up the fund. He was a faithful member of the staffs of St. Joseph's, St. Luke's and Miller Hospitals.

He was married in 1916 to Gwendolen Carter, who survives him. They had three children: Karl, who served three and one-half years overseas in World War II; Josephine, who is a graduate nurse from Miller Hospital and is married to Dr. E. F. Hill of Spring Valley, Wisconsin; and Carter, who is now serving with the Army Air Corps in Massachusetts. In addition to these children, he is also survived by three grandchildren.

WALTER D. BRODIE, M.D.

DAVID D. HILGER, M.D.

David D. Hilger was born April 25, 1877, at Henderson, Minnesota, and died November 12, 1950. In his early years he lived in Pierre, South Dakota. He attended St. Thomas College, Saint Paul, Minnesota, and entered the University of Minnesota Medical School in 1901, graduating in 1905. He interned at Ancker Hospital, Saint Paul, and practiced in Saint Paul thereafter. He was a member of the Ramsey County Medical Society and the Minnesota State Medical Association.

He is survived by five children—three sons, Dr. Jerome A. Hilger, Dr. Laurence D. Hilger of Saint Paul, and Dr. David William Hilger, Oakland, California, two daughters, Mrs. Russell Andre and Mrs. Richard Carley of Saint Paul, and three brothers, Dr. A. W. Hilger and Robert and John Hilger of Saint Paul.

During his long professional life in Saint Paul, Dr. Hilger was beloved by both his patients and his fellow physicians. Even though he retired from practice several years ago, he kept up his interest in his fellow men, and the community of Saint Paul has suffered in the irreparable loss from his death.

J. R. MEADE, M.D.

MILO MARVIN LOUCKS

Dr. M. M. Loucks of Kelliher died suddenly of a heart attack on January 29, 1951, at the age of forty-eight.

Milo Marvin Loucks was born April 8, 1902, in South Dakota. He received his M.D. degree from the University of Minnesota. He was a member of the faculty of the medical school for six years and was in charge of x-ray and the laboratory department at the army hospital at Fort Cook. He practiced at one time in Alvarado. In 1937, he became associated with Dr. A. G. Chadbourn of Heron Lake and in 1943 moved to Northome. He had been located at Kelliher for the past five years.

Dr. Loucks is survived by his wife, Ruth; his mother, Mrs. A. Loucks of Trent, South Dakota, one brother, and four sisters.

GUSTAV SCHWYZER

Dr. Gustav Schwyzer, retired Minneapolis surgeon, died at Biloxi, Mississippi, February 2, 1951, at the age of eighty-three years. He was born in Zurich, Switzerland, March 5, 1867.

He obtained his medical education at the University of Geneva and Zurich, Switzerland, graduating in 1892. He had his postgraduate training under Prof. Theodore Kocher in Berne, Switzerland, where he served as first assistant for several years. He also served as an assistant to Otto Kappler.

He came to America and to Minnesota in 1898. He first practiced surgery in St. Cloud from 1898 to 1902 when he moved to Minneapolis. At the height of his professional career in 1931, he was forced into retirement because of a serious automobile accident. After retiring, Dr. Schwyzer lived at 10701 Lyndale Avenue South, in Bloomington, where he maintained a farm for many years.

While he operated occasionally in other hospitals, almost his entire time was spent at the Northwestern Hospital where he was Chief Surgeon until his retirement. During his active years of practice, he was one

(Continued on Page 262)

GUSTAV SCHWYZER

(Continued from Page 260)

of the most distinguished surgeons in Minneapolis and the State of Minnesota.

Dr. Gustav Schwyzer married Mary Lowry in Minneapolis in 1903, who preceded him in death in 1923. She was the daughter of Thomas Lowry, a pioneer in the development of the Minneapolis Streetcar Company. One son, Warner, is residing in Texas. The late Dr. Arnold Schwyzer of St. Paul was his brother.

Dr. Schwyzer was an excellent general surgeon, but he was primarily interested in the surgery of the thyroid. He contributed many articles to the literature on this subject, about which he was considered an authority. In Halstad's "Operative Story of Goiter" his name is mentioned in the first successful operative cases reported by Kocher in 1898.

He was a charter member of the Minneapolis Club, a member of the Founders Group of the American College of Surgeons, Western Surgical Association, Minnesota Academy, and the American Medical Association, Minnesota State Medical Association, and Hennepin County Medical Society. Besides his association with the Northwestern Hospital, he was also Chief Surgeon for many years at the Minneapolis General Hospital, and surgeon for the Minneapolis Street Railway and Great Northern Railroad.

He was characterized by his attention to discipline and his enthusiasm for his professional work.

He is survived by his wife, the former Agnes Jorgens of Minneapolis, and one son, Werner, of Houston, Texas.

OTTO WILLIAM STERNER

Dr. Otto William Sterner died December 7, 1950, at the age of seventy-two.

Dr. Sterner was born in Sweden, October 1, 1878. He graduated from the University of Minnesota Medical School in 1903 and practiced in Cambridge, Minnesota, until 1915, at which time he moved to Saint Paul to practice with his brother, Dr. Ernest G. Sterner.

Surviving are his wife, Hildegard M., three sons and two daughters.

E. R. Sterner, M.D.

Over 25 million persons suffer from some disabling or nondisabling chronic ailment. Measured in any terms the chronic diseases are a staggering national burden, a major source of insecurity and of loss of national income. The most important of the chronic diseases are heart diseases, arteriosclerosis, high blood pressure, nervous and mental diseases, arthritis, kidney disease, tuberculosis, cancer, diabetes, and asthma. Although the incidence of chronic disease increases with age and the progressive aging of our population is one of the factors responsible for the growing importance of the problem, it is important to remember that chronic illness occurs at all ages.—Vlado A. Getting, M.D., Dr.P.H., *Am. J. Pub. Health*, October, 1950.

Of General Interest

The University of Minnesota has become a brucellosis center for the United Nations World Health Organization. Selected because of its pioneering work on brucellosis, the University is the first of three such centers planned by WHO in the western hemisphere.

The center will be directed by Dr. Wesley W. Spink, professor of medicine, who is also president of the Inter-American Congress on Brucellosis. Dr. Spink and his co-workers have already gained wide recognition for their research work in the diagnosis and treatment of brucellosis in humans.

Similar centers will be established in Argentina and Mexico in the near future.

* * *

Dr. B. F. Fuller has opened offices at 755 Lowry Medical Arts Building, Saint Paul, for the practice of internal medicine and cardiovascular disease.

* * *

Dr. and Mrs. J. Donald Sjoding, Mankato, returned on January 27 from Miami Beach, Florida, where Dr. Sjoding attended the University of Florida midwinter seminar in ophthalmology and otolaryngology. He also attended the midwinter convention of the southern section of the American Laryngological, Rhinological and Otological Society.

* * *

At the annual meeting of the Upper Mississippi Medical Association in Brainerd on January 13, **Dr. Ralph D. Hanover** of Little Fork was elected president of the organization. The meeting was attended by members from eleven north central counties.

* * *

Dr. W. Robert Schmidt, a diplomate of the American Board of Surgery, has opened offices at 408 Physicians and Surgeons Building, Minneapolis, for the practice of thoracic and general surgery.

* * *

At last count the **Veterans Administration** had 114,256 operating beds, with 25,000 additional ones under construction or in the planning stage. Under the out-patient care program, home-town pharmacists filled 736,000 prescriptions last year, and more than 4,500,000 others were filled at VA pharmacies.

* * *

Head of the 1951 Easter Seal campaign in Kanabec County is **Dr. Willard F. Nordman** of Mora. He was named to the position by Frank M. Rarig, Jr., state chairman of the Minnesota Society for Crippled Children and Adults.

* * *

It has been announced that 98.3 per cent of the members of the **Colorado State Medical Society** paid their twenty-five-dollar membership dues to the AMA in time to have them included in a check sent to the national society by Harvey Sethman, executive secretary of the Colorado State Medical Society.

* * *

Dr. Gordon R. Kamman, Saint Paul, spoke on "Mental Health" at a meeting of the American Association of University Women at Albert Lea on February 5. More than 100 persons attended the meeting. On February 13, Dr. Kamman spoke at a meeting of the Cerro Gordo County Medical Society in Mason City, Iowa. His subject there was "Psychotherapy and Psychosomatics."

* * *

On February 1 it was announced that **Dr. Wallace E. Anderson,** Clearbrook, would maintain an office in the Clearwater Clinic at Bagley, starting immediately. It was stated that he would be at the clinic on week-day mornings.

* * *

Dr. Grant L. Griebie left Norwood on February 5 for service in the Army Medical Corps. Beginning service with the rank of captain, he left for Fort Lewis, Washington, where he expected to be stationed at Madigan General Hospital. Dr. Griebie moved to Norwood from Brownton in April, 1949, and was associated in practice with Dr. J. D. Selmo in the Norwood Clinic.

* * *

In the face of a critical shortage of nurses, the **American Nursing Association** has announced that about 40 per cent of registered nurses are not working at the profession and that there are 20 per cent fewer students enrolled in nursing schools than at the end of the war.

In all, there are 506,000 registered nurses—205,000 not practicing, although 87 per cent of these are married. About 100,000 students were enrolled in nursing schools in 1950, against 127,000 at the end of the war. The ANA, AMA and the Army are cooperating in a campaign to get older nurses who have retired to go back into practice, releasing the younger nurses for military duty. The Army needs 3,000 nurses by June.

* * *

The number of physicians in rural areas might be increased by accepting more medical students from such areas, **Dr. Harold S. Diehl,** dean of medical sciences at the University of Minnesota, suggested at a meeting in Chicago on February 12. Speaking at the forty-seventh annual Congress on Medical Education and Licensure, Dr. Diehl said that a survey of graduates of the University of Minnesota Medical School showed that the chances of a student brought up in a community of less than 5 000 returning to such an area are 2½ times as great as a metropolitan student going to the country.

(Continued on Page 266)

(Continued from Page 264)

Dr. Mentor H. Christensen and Miss Laura Mae Carpenter, of Minneapolis, were married in the Fort Snelling chapel on January 27. Dr. Christensen, formerly on the staff of the Minneapolis Veterans Hospital, has been recalled into service with the Air Force.

* * *

The Mineral Springs Sanatorium Commission announced on February 16 the appointment of **Dr. Ezra V. Bridge** as medical director and superintendent of Mineral Springs Sanatorium at Cannon Falls. He succeeds Dr. Karl H. Pfuetze as head of the sanatorium.

Dr. Bridge is a graduate of the Cornell University Medical College and has had extensive training in tuberculosis work. Before his appointment at Mineral Springs Sanatorium he was supervising tuberculosis physician at the J. N. Adam Memorial Hospital, Perrysburg, New York.

* * *

Principal speaker at a meeting of the Twin City Society of Medical Technologists in Saint Paul on January 10 was **Dr. John Rukavina,** who spoke on "Sickle Cell Anemia."

* * *

Dr. David A. Boyd, member of the section on neurology and psychiatry of the Mayo Clinic, Rochester, was a speaker on the program of the fifth annual Michigan Postgraduate Clinical Institute, held in Detroit on March 14, 15 and 16. Dr. Boyd spoke on "The Psychological Language of the Organs."

* * *

The newest member of the Minnesota Poll advisory board is **Dr. J. F. Norman,** Crookston, president of the Minnesota State Medical Association. Made up of twenty leading Minnesotans, the board is consulted by the Poll staff on issues to be studied in statewide public opinion surveys. The Minnesota Poll is conducted by the *Minneapolis Tribune* as a public service.

* * *

It was announced late in February that **Dr. F. H. Dickson,** of Proctor, planned to leave on March 15 by plane for a month's trip to Europe. His plans called for spending several days in England studying their socialized medicine arrangements, in preparation for writing and giving lectures upon his return home. He also planned to attend special medical clinics in London and Paris.

* * *

Dr. Edward Dyer Anderson, Minneapolis, was named a new director of the Minnesota Mental Hygiene Society on February 20. His term as a director extends until 1954.

* * *

The newly constructed Kerkhoven Health Center was opened for use on January 2. Occupied by **Dr. B. C. Ostling** and a dentist, the building was con-

structed by residents of the area to provide office space for local doctors. A corporation was formed by the people in the area, stock was sold, and erection of the building began last summer. Offices in the structure are rented by the corporation to make the building completely self-sustaining.

* * *

Dr. **D. E. Affeldt** was appointed village health officer at the annual meeting of the Kasson village council on January 2.

* * *

Dr. **G. M. A. Fortier,** of Little Falls, is head of the 1951 Easter Seal campaign in Morrison County.

After serving for thirteen years as Winona County physician, **Dr. C. P. Robbins,** Winona, notified the county board on January 2 that he would not be a candidate for the post in 1951. He stated that he would be unable to continue as county physician due to ill health.

* * *

Dr. William A. Coventry, Duluth, was honored for outstanding service to St. Mary's Hospital in Duluth at the annual meeting of the hospital's medical staff on February 1. He was presented with an engraved scroll expressing appreciation for his work. It was the second time in the hospital's history that

such an award had been given. In 1947, Dr. E. L. Tuohy was the recipient of a similar award.

* * *

Dr. and Mrs. L. A. Dwinnell, formerly of Fergus Falls, have moved to Rochester, where Dr. Dwinnell has begun a three-year fellowship at the Mayo Clinic.

* * *

A University of Minnesota graduate, **Dr. Harold M. Graning,** has been appointed regional medical director of the public health service for Minnesota, Illinois, Indiana and Wisconsin. The appointment was the first step in a program to strengthen the regional setup of public health staffs. Dr. Graning, who was graduated from the University of Minnesota Medical School in 1937, has been with the public health service since 1938.

* * *

Dr. Willard C. Peterson, Minneapolis, discussed the everyday life of a physician at a meeting of the Macalester College Premedical and Dental Club in Saint Paul on February 13.

* * *

Among those in attendance at a continuation course in geriatrics at the University of Minnesota on January 4, 5 and 6 was **Dr. Hugh D. Patterson** of Slayton.

* * *

Early in January, **Dr. J. M. Cook** of Staples was appointed deputy coroner for Todd County by **Dr. A. J. Lenarz** of Browerville, who was elected coroner at the general election in November.

* * *

Dr. T. R. Fritsche, New Ulm, has been appointed medical officer on the state guard staff of General Russell B. Rathbun, Minneapolis. With the new appointment Dr. Fritsche became head of the medical staff of the units in all cities in which the new Minnesota State Guard is being organized.

* * *

Dr. Frederick A. Figi, consultant in the section on laryngology, oral and plastic surgery at the Mayo Clinic, Rochester, participated in a panel discussion on neck surgery and in a cancer symposium at the sectional meeting of the American College of Surgeons in St. Louis on January 22.

* * *

Dr. George D. Haggard, said to be Minnesota's oldest practicing physician, celebrated his ninety-fifth birthday in Minneapolis on January 18.

* * *

The resignation of **Dr. L. H. Flancher** as superintendent of the Sand Beach Sanatorium at Lake Park was accepted by the Clay-Becker county boards and the sanatorium commission on January 17. Dr. Flancher left on February 1 to become head of Sunnyrest Sanatorium at Crookston. He had been superintendent at the Sand Beach institution since 1925, except for eight years between 1941 and 1949 when

he headed the tuberculosis department of the Iowa State Health Department.

* * *

Dr. Gerald N. Hofmann, staff member of the Mineral Springs Sanatorium, conducted a Mantoux testing clinic in Red Wing on February 5.

* * *

The first mental health clinic for children in Minneapolis was officially opened on February 9. The clinic, the **Washburn Memorial Clinic** at St. Barnabas Hospital, is believed to be the only one in the country sponsored jointly by a private hospital and a state university. **Dr. Harold B. Hanson,** director, was formerly director of the Minneapolis Board of Education's child study department.

Minnesota children up to sixteen years of age will be treated at the clinic on referral from other physicians. The clinic's staff will be supervised by faculty members of the University of Minnesota Medical School.

* * *

Dr. Thomas Page Anderson of the Mayo Foundation, has been appointed director of the Department of Physical Medicine at the new Medical Health Center at Ohio State University. Dr. Anderson has been a fellow in physical medicine at Rochester since January, 1948.

Dr. C. A. Rohrer of Waterville suffered a broken arm when another car collided with his on a highway near Morristown on January 26. Three other persons were also injured in the accident.

* * *

Word was received early in February that **Dr. John R. Utne,** formerly of Northfield, was in Korea with the First Cavalry Division of the Eighth Army. Dr. Utne was called into service in November, 1950.

* * *

Elmore lost one of its two physicians early in January when **Dr. Harry Shragg** left to begin work at the Minneapolis Veterans Hospital. Remaining in Elmore is Dr. Troy Rollins.

* * *

Dr. Philip S. Hench and **Dr. Edward C. Kendall,** Nobel Prize winners, were guests of honor at a formal reception held by the board of governors of the Mayo Clinic and the Mayo Foundation in Rochester on January 12. On display at the reception were the medals and diplomas presented the two winners by the Nobel Prize committee.

* * *

Dr. Charles W. Vandersluis, Bemidji, resigned as county coroner on January 3 after officially holding the position for only two days. The county board then appointed **Dr. Bernard S. Nauth,** Bemidji, to replace him. Backing Dr. Nauth's appointment, Dr. Vandersluis stated that he had resigned because of

the press of duties from his practice and his position as city health officer. "The main reason I ran for the office," he said, "was because I am of the firm conviction that the office of county coroner is one for a doctor and not for an undertaker."

* * *

Dr. Leonard A. Lang, Minneapolis, was the principal speaker at a meeting of the St. Thomas College Aesculapian Club in Saint Paul on January 17.

* * *

Holiday Home at Lake Geneva, Wisconsin, will be open to eighty diabetic children, aged eight through fourteen, from June 25 to July 16. The camping period is sponsored by the **Chicago Diabetes Association.**

The need for such a camp in the Midwest was apparent in 1949 when Holiday Home provided the facilities to care for the younger diabetics and give them the advantage of summer camping. The contributions of such experience to the development of a normal child are obvious. A schedule of the usual camping activities is maintained under supervision of a trained medical, dietary, nursing and counseling staff. Included are swimming, handicrafts, nature study, boating, tennis and other pursuits which encourage the child in the direction of a normal balanced life. Association with other diabetics in this program gives the camper a feeling of group security difficult to achieve in the home.

Detailed medical analysis of the 1950 camping season, general information and applications are available on request. Inquiries should be sent to the Chicago Diabetes Association, Inc., 950 East 59th Street, Chicago 37, Illinois.

* * *

Dr. Ralph Wenzel, Blue Earth, announced early in January that he was moving to Columbus, Georgia, to start a private practice. Dr. Wenzel began practice in Blue Earth in 1948, in association with Dr. George Drexler, with whom he formed the Blue Earth Medical Center.

* * *

It was announced on February 7 that **Dr. Edward C. Kendall,** head of the Mayo Clinic's biochemistry laboratory and one of the winners of the 1950 Nobel Prize in medicine, will retire from the Mayo Foundation on May 1. It was stated that his future plans were indefinite but that he did not plan to cease working.

* * *

Dr. James J. Warner, of Perham, and Miss Mary Margaret Larson were married on February 6 at St. George's Episcopal Church in Minneapolis. They planned to spend their honeymoon in Hawaii.

* * *

Dr. A. H. Benson, formerly of Washington, D. C., announced on January 24 that he had taken over the practice of **Dr. R. V. Fait** in Little Falls. Dr. Fait, who has practiced in Little Falls since 1936, is moving to California to set up a practice.

A graduate of Loyola University, Dr. Benson practiced in northern Michigan for five years. For

the past five years he has specialized in genito-urinary diseases and surgery at Washington, D. C.

* * *

Dr. C. A. McKinlay, Minneapolis, showed color pictures of his recent trip to Europe at a meeting of the Hamline-Asbury Nurse Alumnae Association in Minneapolis on February 5. While in Europe, Dr. McKinley attended the annual congress of the International Cardiological Society in Paris.

* * *

Dr. L. E. Steiner, Albert Lea, was appointed deputy coroner of Freeborn County on January 3. Coroner for the county is **Dr. S. G. Egge.**

* * *

Dr. Wallace C. Hill moved from Pequot Lakes on January 12. Dr. Hill now has a fellowship in surgery at the University of Michigan at Ann Arbor, Michigan.

* * *

On December 29 **Dr. F. Donald Bucher** moved his offices into a newly constructed clinic building in Starbuck. The one-story, 30- by 50-foot building also houses a dental suite in addition to Dr. Bucher's offices.

* * *

Dr. R. S. Ylvisaker, Minneapolis, was re-elected president of the **Minneapolis War Memorial Blood Bank** at the annual meeting of the board on January 18. Other officers include **Dr. Nathaniel H. Lufkin, Dr. Thomas Lowry** and **Dr. Mancel T. Mitchell,** vice presidents.

At the meeting **Dr. G. Albin Matson,** director of the blood bank, reported that 11,827 units of blood were drawn from donors during the 1950 fiscal year. During the previous year the bank drew 8,823 units.

* * *

A diabetic survey began in Hibbing schools on January 29. Tests were run in school laboratories, with five teams of ten students each doing the work. The teams of high school and junior college students were supervised by **Dr. Rufus Johnston,** school health officer, and **Dr. Robert Murray,** township health officer. Plans called for testing about 4,500 students and school employes. A similar survey was completed for the adult population of Hibbing last year.

* * *

Dr. John B. Evensta, formerly of Minneapolis, has become associated in practice with Dr. Gordon M. Erskine and Dr. Clarence R. Ferrell of Grand Rapids. Dr. Evensta is specializing in surgery.

* * *

Dr. Kenneth W. Covey, Mahnomen, was named "Young Man of the Year" by the Mahnomen Junior Chamber of Commerce at their annual banquet on January 15. The award was presented to Dr. Covey because of his numerous contributions to civic and community life and his continued interest in the all-around progress of the community.

* * *

Dr. Dexter E. Guernsey, formerly of Minneapolis, has completed a fellowship in surgery at the Mayo

Clinic and has moved to San Francisco to begin private practice there.

* * *

Dr. A. D. Hoidale, who retired from active practice in Tracy more than a year ago, resumed his practice on February 15. His return was caused by the shortage of physicians which resulted when two local doctors were called into military service.

It was announced on February 8 that Tracy would acquire another physician early in July. He is **Dr. Malcolm M. Fifield,** who is now completing a two-year fellowship at the Navy Hospital at Bremerton, Washington.

* * *

Dr. S. Marx White, Minneapolis, was presented with the annual distinguished service award of the Community Chest and Council of Hennepin County at its annual meeting in Minneapolis on January 31. Dr. White, who has practiced in Minneapolis for more than fifty years, has an impressive record of service in community health activities. He has been president of the Minnesota State Board of Health, a member of the Hennepin County Sanatorium Commission, a director of the Hennepin County Tuberculosis Association, and president of the Community Chest and Council. He was a member of the University of Minnesota Medical School faculty from 1898 to 1942.

* * *

Dr. Charles W. Mayo, Rochester, has been elected a regent of the University of Minnesota, replacing Mr. A. J. Lobb, business manager of the Mayo Clinic, who resigned in January upon reaching the Mayo Clinic retirement age. Dr. Mayo's election continues a thirty-eight-year-old tradition that has kept a representative of the clinic on the board of regents.

* * *

Dr. and Mrs. E. R. Bray, Saint Paul, left on February 23 for Hot Springs, Virginia, where Dr. Bray attended a meeting of the American College of Surgeons.

* * *

The fiftieth anniversary of the Minnesota chapter of **Alpha Epsilon Iota,** national medical sorority, was celebrated in Saint Paul on February 21. Chairman of arrangements for the anniversary was Dr. Catherine Corson West of Minneapolis.

* * *

The Triumph-Monterey Community Hospital received a gift of equipment early in February from **Dr. Robert C. Farrish** of Sherburn. The equipment included an emergency table, instrument cabinet and instruments. Construction of the new hospital is nearing completion.

* * *

The Austin Clinic announced on February 12 that **Dr. Harold J. Anderson,** formerly of Saint Paul, had joined the clinic staff. A graduate of the University of Minnesota Medical School in 1944, Dr. Anderson served his internship at Minneapolis General Hospital, then entered the Army for two years. Following his return to civilian life, he took specialized

training in surgery at Minneapolis General and the University of Minnesota Hospitals. His practice in Austin will be limited to surgery.

* * *

Among the speakers on the program of the **Hennepin County Health Day** in Minneapolis on January 26 were Dr. Tague C. Chisholm, Minneapolis pediatric surgeon; Dr. C. Knight Aldrich, professor of psychiatry at the University of Minnesota, and Dr. Edward L. Tuohy of Duluth.

* * *

On February 14 **Dr. A. E. Sohmer** of Mankato retired from active practice. A graduate of Brooklyn's Long Island College in 1899, Dr. Sohmer practiced in Buffalo, New York, until 1910, when he moved to Mankato. For five years he was a general practitioner in Mankato, and in 1916 he began to specialize in general and urological surgery.

Dr. Sohmer is a past president of the Blue Earth County Medical Society and the Southern Minnesota Medical Society, and a former vice president of the Minnesota State Medical Association.

* * *

A bronze plaque honoring **Dr. M. S. Henderson,** a retired staff member of the Mayo Clinic, was installed in St. Mary's Hospital, Rochester, early in January. The plaque honored Dr. Henderson for his work in organizing the hospital's orthopedic section.

* * *

Dr. Karl S. Klicka became the new medical director of St. Barnabas Hospital, Minneapolis, January 1, 1951. Dr. Klicka is a graduate of Western Reserve University medical school, Cleveland, Ohio, and took advanced training in hospital administration at the University of Chicago. He has been director of Woman's Hospital, New York, since his discharge from the Army in 1945.

* * *

Dr. E. J. Lillihei was elected chief-of-staff at St. Barnabas on February 7. Chosen as vice chief-of-staff was **Dr. Robert J. Tenner;** as secretary-treasurer, **Dr. Edgar A. Webb.** At the same time the appointment of Clarence N. Hardenbergh as chairman of the St. Barnabas board of directors was announced. Mr. Hardenbergh succeeds Charles Bolles Rogers as chairman.

BLUE CROSS—BLUE SHIELD NEWS

Payments to physicians for subscriber medical service by Blue Shield in 1951 were more than ten times as much as those of 1948, and twice those of 1949. In 1950 these payments amounted to $2,249,032; in 1949, $1,156,231; and in 1948, $169,269. The 1950 payments represented 58,568 claims for 70,893 services including all ancillary services.

For December 1950 alone, payments totalled $265,637.79 for 7,528 claims. This represents an increase of $63,788.16 over November. These payments covered 5,501 hospitalized cases, 1971 cases of care in the doctor's office or clinic, and 56 cases in which care was rendered in the patient's home. Subscribers with in-

comes over $2,000 or $3,000 annually, if single or married respectively, received the benefits in 5,499 claims, and 2029 claims of subscribers with incomes less than those mentioned were paid.

As a result of the sharp increase in the number of claims filed with and processed by Blue Shield, it has been found necessary to analyze the age of claims as filed. For instance, of the 7,528 claims processed in December, only 1,258 were for services in December, whereas 3,180 were for November services and 1,652 for October. Of those remaining 177 were over six months old and of these 20 were over a year old.

Delay in filing and paying claims is due to a variety of factors. From the administrative viewpoint, Medical Service Reports often do not contain enough information to evaluate and pay the claim; evidence that preexistence of the condition may invalidate the claim makes it necessary to secure previous medical history from both doctor and subscriber; and in some instances the subscriber fails to advise the doctor that he has a Blue Shield policy for several months after the service is provided. Since the doctor's office is the liaison between the patient and Blue Shield, in many cases the only means of personal contact, Blue Shield relies on this contact to assist wherever possible in seeing that claims are properly submitted.

The professional relations subject is not one which is under consideration only by Minnesota Blue Shield. From February 1 to 3, 1951 approximately 200 representatives of Blue Cross and Blue Shield plans throughout the nation attended a Blue Cross-Blue Shield Hospital and Physician Relations Conference, captioned "Prescription for Profitable Professional Relations." The general discussions and panel meetings centered about ways and means by which better professional relations could serve to improve the workings of both Blue Cross and Blue Shield. Questions pertaining to diagnostic studies, hospital admittances, home and office calls and the avoidance of the overuse of hospital ancillary services were the chief topics. There was also discussion about the desirability or advisability of forming an organization of medical directors of Blue Shield and Blue Cross which might possibly serve on an advisory basis to the Blue Cross-Blue Shield Commission. Suggestions made for better professional relations included the effective use of plaques in the doctor's office and possibly the hospital waiting rooms, improved means for assisting the patient to identify his Blue Cross-Blue Shield eligibility, and the use of stickers on hospital charts to prevent overstay.

SOCIALIZED MEDICINE CALLED ALIEN BLIGHT

(Continued from Page 248)

has an honored profession encountered such a difficult situation."

The list of barriers blocking the way in medicine's fight includes:

". . . the bureaucracy became its chief exponent. Since then, volumes of 'official' and inspired propaganda have been issued, mainly at public expense.

"Federal employes have served as exhorters and lobbyists.

"In the Department of Justice the antitrust laws have been distorted to persecute ethical medical societies.

"The whole weight of the federal government and the inexhaustible finances of the federal treasury, have been misused to destroy the freedom of medical practice and to put medical science under political control."

The newspaper called all these things "unscionable oppression," and applauded the medical profession for leading the opposition against them:

"Against this unscionable oppression—for it is nothing else—the medical profession has reacted COURAGEOUSLY and CONSTITUTIONALLY.

"The profession is exercising ITS OWN RIGHT OF PETITION by appealing to the American people—and so, to the Congress of the United States.

"The doctors are battling for FREEDOM, not for monetary gains.

"In every calling, as in every community, the fight against socialism must be made.

"The doctors are showing other Americans how to make it."

The total blind population now in the United States is believed to be over 260,000.—Christmas Seal Health Release.

BOOK REVIEWS

Books listed here become the property of the Ramsey, Hennepin and St. Louis County Medical Libraries when reviewed. Members, however, are urged to write reviews of any or every recent book which may be of interest to physicians.

PRACTICAL GYNECOLOGY. *Walter J. Reich,* M.D., F.A.C.S., F.I.C.S., Attending Gynecologist, Cook County Hospital; Professor of Gynecology, Cook County Graduate School of Medicine; Attending Gynecologist, Fantus Clinics of the Cook County Hospital; Assistant Professor of Gynecology, Chicago Medical School; Attending Gynecologist and Obstetrician, Grant Hospital; Attending Gynecologist, Fox River Tuberculosis Sanatorium; Consulting Gynecologist, Hazelcrest General Hospital; and *Mitchell J. Nechtow,* M.D.; Associate Attending Gynecologist, Cook County Hospital and the Fantus Gynecologic Clinic; Assistant Clinical Professor of Gynecology, Cook County Graduate School; Associate in Gynecology and Obstetrics, Chicago Medical School; Attending Gynecologist and Obstetrician, Norwegian-American Hospital. 449 Pages Illus. Price $10.00 Philadelphia: J. B. Lippincott, 1950.

"Practical Gynecology" was formulated from the authors' experiences in conducting classes at the Cook County Graduate School of Medicine and in the gynecologic out-patient clinics at the Cook County Hospital. The book was written to fulfill the needs of the general practitioner as a handy aid toward establishing a diagnosis, and utilizing practical procedures suitable to the office management of medical and minor surgical diseases in gynecology. The book is not concerned with major operative gynecological procedures, and if such information is desired one is referred to standard textbooks pertinent to the subject being discussed.

Busy practicing physicians are likely to hurry patients along, and in gynecology, as well as in all fields of medicine, a careful history and thorough physical examination are so essential at arriving at a proper diagnosis that one should take time to listen to patients. A timely remark by the authors which impressed me was that the patient "talks her story in her own words" and "we have made it a habit to be good listeners."

There are seventeen chapters: Psychosomatics of Gynecology, Practical Approach to a Gynecological Diagnosis, Biopsy and the Early Detection of Cancer, Laboratory Findings in Gynecology, Reproductive Endocrinology, Menstruation, Disturbances of Menstrual Function, Anomalies and Malposition of the Female Genitalia, Inflammatory Lesions, Infection, Traumatic Lesions, Neoplasms, Common Gynecological Complaints, Genital Fistulas, Technics and Apparatus, Low Fertility and Sterility, Premarital Examination and Counsel.

Comments regarding the material contained in the above chapters is not warranted, because the material contained therein is discussed in a fundamental, practical and useful manner. There are several sections in the book which are exceptionally worth-while. Drs. Reich and Nechtow, in the section on Psychosomatic Approach to Sexual Problems, have offered simple approaches to the solution of very personal problems. The last chapter on Premarital Examination and Counsel is one which

adds to the value of the book for its intended purpose.

Anyone practicing office gynecology, general practitioner or gynecologist, should read the paragraphs pertaining to vaginal pessaries—indications and method of application.

The title "Practical Gynecology" describes the book in the simplest of terms. It should be valuable to any physician who treats gynecological patients.

J. F. MELANCO, M.D.

PROGRESS IN GYNECOLOGY. Volume II. Edited by Joe V. Meigs, M.D., Clinical Professor of Gynecology, Harvard Medical School; Chief of Staff of the Vincent Memorial Hospital, the Gynecological Service of the Massachusetts General Hospital; Surgeon, Pondville Hospital; Gynecologist, Palmer Memorial Hospital, and Somers H. Sturgis, M.D., Clinical Associate in Gynecology, Harvard Medical School; Assistant Surgeon, Massachusetts General Hospital, Boston, Massachusetts. 821 Pages. Price, $9.50. New York, Grune & Stratton, 1950.

In this volume, the editors, Joe Vincent Meigs, and Somer H. Sturgis, again as in Volume I, have asked contributors to write on specific subjects and have received an excellent response. In addition to their own contributions, they obtained material from scores of others and always from those who excel or are interested in one particular phase. In other words, they asked men to write on their hobbies and therefore the masterfully selected and arranged chapters could be termed a "Parade of Hobbies." And what a parade it is! The chapters are carefully arranged and also overlap in certain cases to cover a subject from different viewpoints. This is not repetition, but a very helpful way to impress and drive home points. The volume again is primarily intended for those limiting their field of practice and for residents, but much man be gleaned from it by general practitioners or those wishing to refresh their knowledge.

The book opens with an excellent chapter on Embryology as a setting, and then proceeds in Physiology, Diagnostic Methods, Functional Disorders, and a very understandable chapter on the Inter-relationship on Endocrine Glands. It then deals with a very interesting and hard problem of Sterility, Infections of the Genital Tract, Treatment of Benign and Malignant Growths, and the newer operative techniques for various difficult conditions. It closes with pre-operative and postoperative care. When the book is thoroughly perused, one gets a very clear and up-to-date refreshing on confronting problems. It is an excellent volume and indispensable to anyone interested in gynecology or wishing to be well posted on gynecological problems.

JOSEPH F. BICEK, M.D.